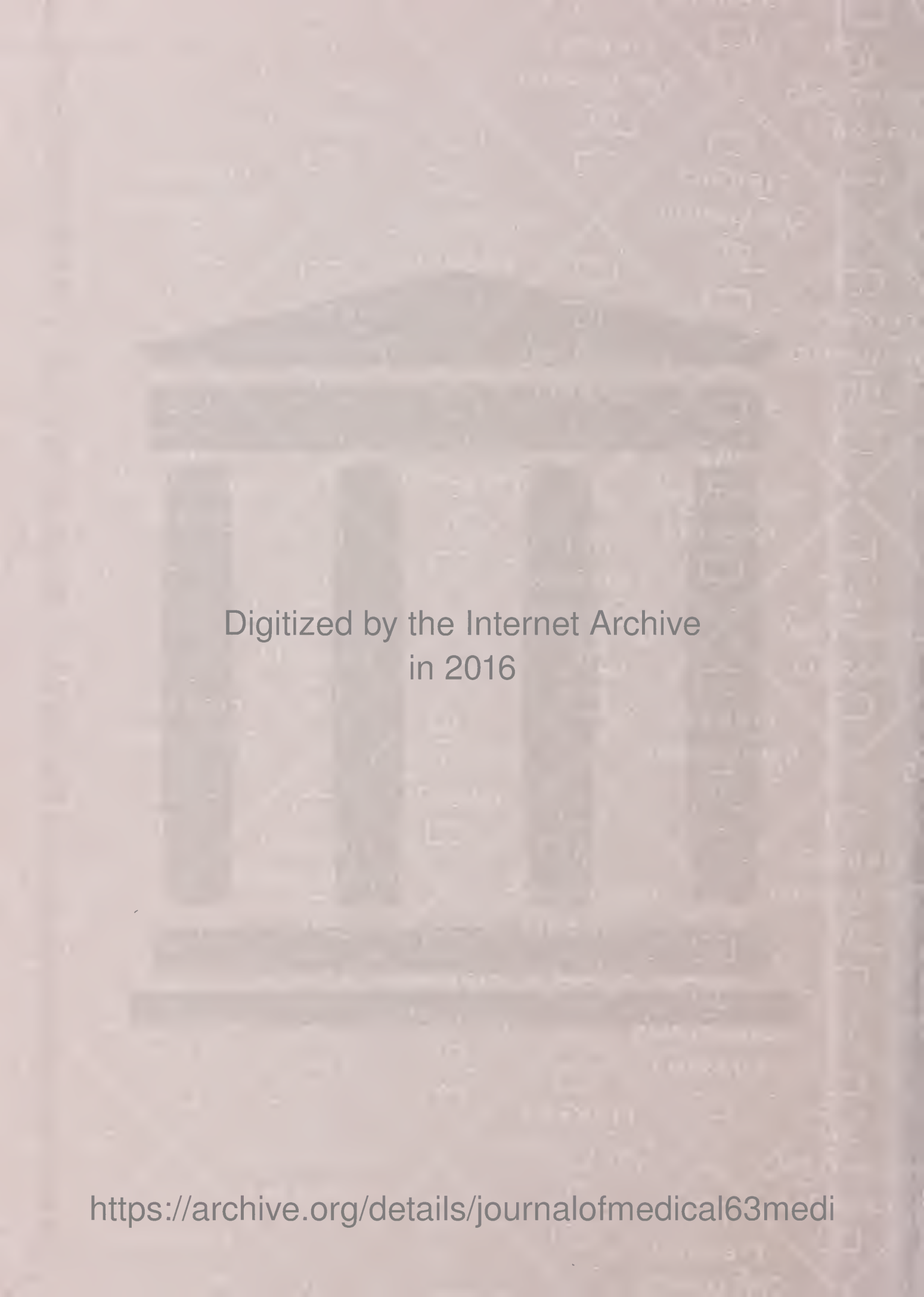
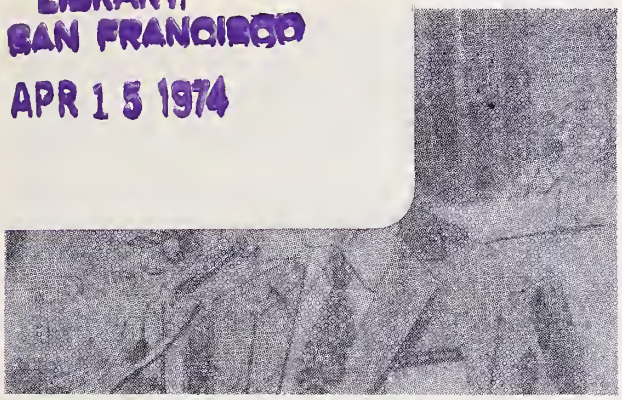

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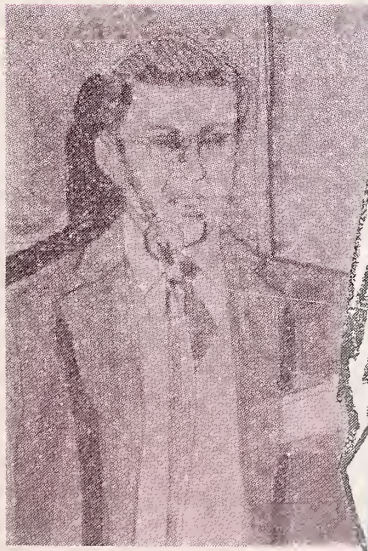
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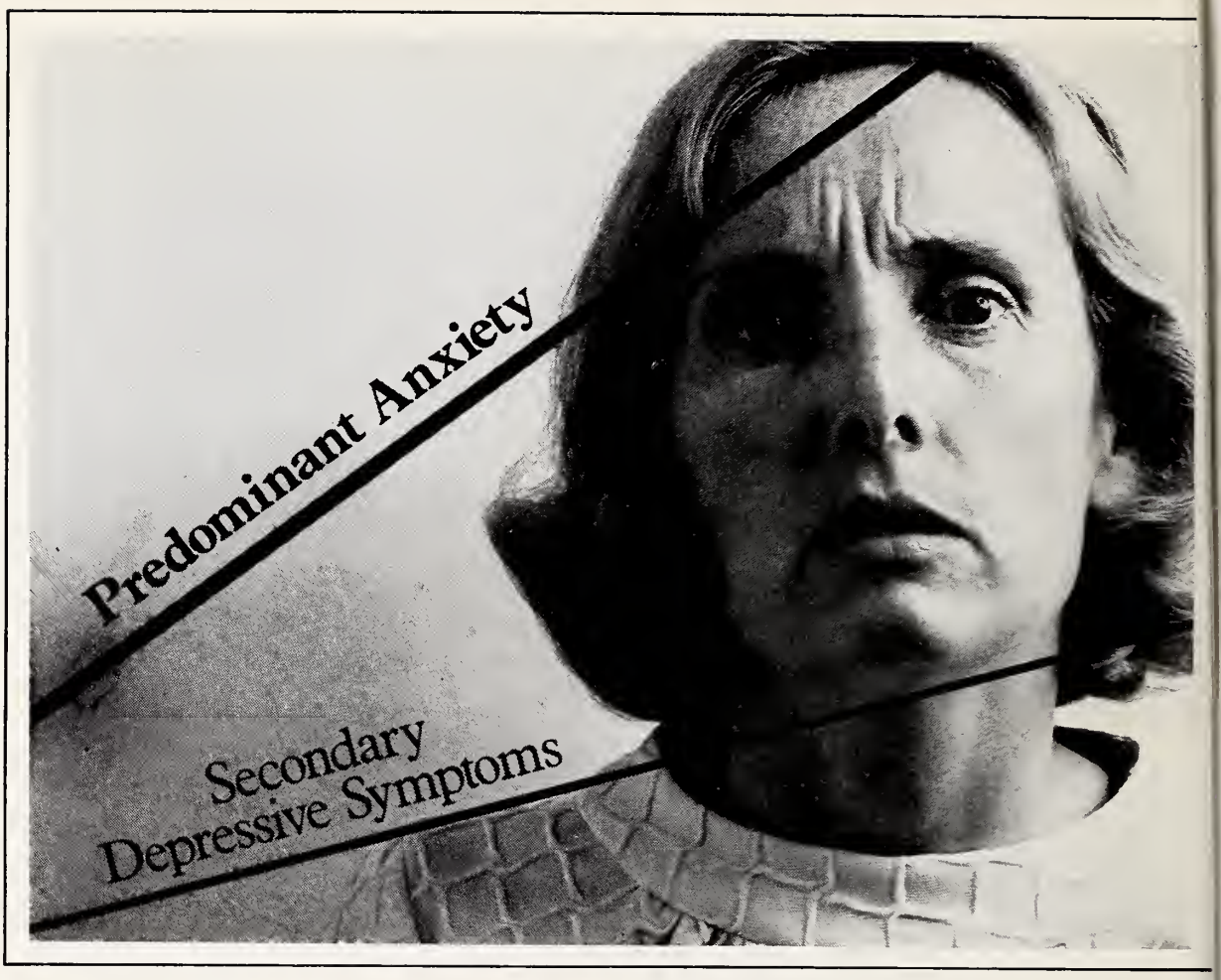








Special Session
Proceedings



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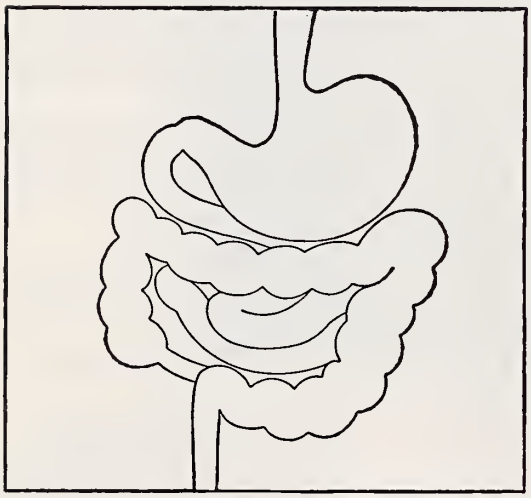
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THE COVER

Photographs of December's historic Special Session, which considered PSRO and EMCRO, inspired this design by Atlanta artist Bob Hamill.

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Special Session—House of Delegates
Saturday, December 15, 1973

THE SPECIAL SESSION of the House of Delegates of the Medical Association of Georgia was called to order by Speaker Harrison L. Rogers, Jr., M.D., Atlanta, at 9:00 a.m. in the North Ballroom, Marriott Motor Hotel, Atlanta, Georgia.







Above: PSRO Committee Chairman Charles D. Hollis, Jr. Center: House Speaker Harrison L. Rogers, Jr. with EMCRO Committee Chairman Ollie O. McGahee, Jr. Right: Cobb delegate Donald R. Rooney addresses the House.

The Speaker called on F. William Dowda, M.D., Atlanta, for the invocation.

Speaker Rogers then made brief remarks during which he extended greetings to the delegates and advised the assembly that this Special Session had been properly called pursuant to Article VII, Section 3 of the MAG Constitution and Bylaws. The Speaker further pointed out that pursuant to the official call of the Special Session the matters on the agenda for the meeting would be the Experimental Care Review Organization (EMCRO) and Professional Standards Review Organization (PSRO).

Speaker Rogers announced the appointment of the Credentials Committee and the Tellers Committee as follows:

CREDENTIALS COMMITTEE:

S. William Clark, Waycross, chairman
J. H. Deaton, Columbus
J. Kenneth McDonald, Augusta

TELLERS COMMITTEE:

Beverly B. Sanders, Macon, chairman
William D. Dooley, Rome
James M. Skinner, Griffin

Speaker Rogers called for a report of the delegates in attendance. Dr. Clark, chairman of the Credentials Committee, reported that there were 71 delegates representing 40 component medical societies in attendance and accordingly announced that a quorum was present. (A final tally of the Credentials Committee indicated a first day attendance at this Special Session of 135 duly elected delegates.)

Attendance

BALDWIN: W. R. Howard; BIBB: Charles Duggan, Warren L. Griffin, Jr., F. V. Kay, C. G. Magnan, Jack Menendez, S. Charlotte Neuberg, B. B. Sanders; OGEECHEE RIVER: Leon E. Curry; CARROLL-

DOUGLAS-HARALSON: J. Larry Boss, Clark Robinson; GEORGIA MEDICAL SOCIETY: Burton D. Goodwin, Frank M. Johnston, J. Robert Logan, F. Debele Maner, J. V. Morrison, Joseph A. Mulherin, Dearing H. Nash, Julian K. Quattlebaum; ELBERT: John B. O'Neal; CHEROKEE-PICKENS: C. J. Roper; CRAWFORD W. LONG: Donald L. Branyon; CLAYTON-FAYETTE: Wells Riley; COBB: F. Norman Bowles, Remer Y. Clark, Steve May, James H. Manning, Gary Palmer, Charles Rey, Donald R. Rooney, Charles Underwood; CHATTAHOOCHEE: Rupert H. Bramblett; COLQUITT: John Pierce Tucker; DEKALB: Duane Blair, Timothy Harden, Jr., John P. Heard, Kenneth Hoose, Jr., Charles McDowell, LaMar McGinnis, Frank E. Morgan, Jr., Benjamin Okel, William J. Rawls, Roy Vandiver; DOUGHERTY: J. Dan Bateman, D. M. Boyette, Charles D. Hollis, Robert D. Waller; FLINT: J. T. Christmas; FLOYD-POLK-CHATTOOGA: James A. Routledge, Jack M. Waldrep; MEDICAL ASSOCIATION OF ATLANTA: T. J. Anderson, Jr., John S. Atwater, Linton H. Bishop, J. T. Blasingame, James N. Brawner, Spencer S. Brewer, Jr., F. William Dowda, Edwin C. Evans, Louis Felder, Joseph L. Girardeau, Irving L. Greenberg, Charles E. Harrison, J. Harold Harrison, J. Rhodes Haverty, Armand E. Hendee, L. W. Hobby, J. R. B. Hutchinson, C. R. Moorhead, Fleming L. Jolley, W. Dan Jordan, James A. Kaufmann, William D. Logan, John T. McCain, John M. McCoy, William W. Moore, Keith Quarterman, Harold S. Ramos, A. A. Rayle, Lea Richmond, Harrison L. Rogers, John K. Schellack, Lee R. Shelton, Parry Soder, Ignatius Stein, Thomas L. Tidmore, Jr., Charles E. Todd, Edward J. Waits, Robert E. Wells, Frank L. Wilson, Joseph S. Wilson, D. C. Whitney; GLYNN: M. A. Glucksman, Edwin A. Mayo, William J. Smith; GORDON: R. D. Walter; HABERSHAM: Thomas N. Lumsden; HALL: Larry N. Durisch, Donald R. Luke, Harvey Newman; PEACH-BELT: W. E. Weems; JACKSON-BANKS: E. W. Holloway; LAURENS: O. B. Johnson, Robert Oliver; MCDUFFIE: Thomas E. Averitt; MUSCOGEE: J. H. Deaton, J. A. Raines, B. R. Maughon, E. M. Molnar, Bruce C. Newsom, R. E. Thompson; RICHMOND: Joseph P. Bailey, Jr., James L. Becton, Claude Boyd, Curtis Carter, Ronald F. Galloway, J. Kenneth McDonald, Stuart H. Prather, Jr., Henry D. Scoggins, Luther J. Thomas, Jr.; SOUTH GEORGIA: Frank Eldridge, Joe C. Stubbs; SPALDING: James Skinner; STEPHENS: Peter C. Lampros; THOMAS AREA: Frank R. Miller; TROUP: Joseph M. Almand, H. Hilt Hammett; WALKER-CATOOSA-DADE: Ted D. Cash, M. K. Cureton; UPSON: T. A. Sappington; WARE: F. E. Davis, S. W. Clark; WASHINGTON: William Rawlings; WAYNE: Ollie O. McGahee, Jr.; WHITFIELD: James Oosterhoudt, Jr.; WILKES: M. G. Adair; WORTH: H. G. Davis.

Speaker Rogers departed from the order of business at this point to announce that MAG had been informally advised that the Department of Health, Education and Welfare will propose that Georgia be divided into three PSRO areas effective January 1974. The Speaker advised that MAG would file a vigorous protest with HEW and urge single area designation for Georgia. The Speaker then indicated how HEW might subdivide Georgia into three PSRO areas (as indicated previously by Region IV of HEW).

Dr. Rogers then introduced L. S. Buchanan, M.D., Decatur, vice speaker of the House of Delegates, and advised the House that Dr. Buchanan would preside with the Speaker throughout the two-day proceedings.

Informal Consideration

The Speaker asked for approval of the proceedings of the House of Delegates held in May 1973, as those proceedings form, in part, the basis on which this meeting of the House of Delegates was held. The Speaker asked specifically that the proceedings of the House of Delegates convened on May 11-13, 1973, which were published in the June 1973 issue of the *Journal of the Medical Association of Georgia,* be approved. It was moved, seconded and adopted by the House that these minutes be approved. Speaker Rogers explained that the complexity of the issues facing the House of Delegates plus the brevity of the meeting made the use of reference committees usually employed by MAG House of Delegates meetings an impractical way for the House to conduct its business at this meeting. Accordingly, the Speaker announced that the Chair would entertain a motion to proceed under a device contained in Sturgis' Code of Parliamentary Procedure known as "informal consideration" which would permit the entire House to function much the same as a reference committee.

Following the Chair's explanation of "informal consideration," Dr. Earnest C. Atkins, secretary of the Medical Association of Georgia, moved that the House of Delegates give informal consideration to the matter of the Georgia Experimental Medical Care Review Organization (EMCRO). This motion was adopted by the House.

Speaker Rogers announced that the House of Delegates would consider PSRO upon completion of its consideration of EMCRO, and would not, in fact, wait until the following day (December 16) before commencing consideration of PSRO as may have been indicated in the official call of the meeting. He advised, however, that voting on PSRO would not begin until December 16.

Pursuant to the Atkins amendment to consider Experimental Medical Care Review Organization informally, EMCRO then became the business pending before the House. Speaker Rogers gave a brief review of the May 1973 House of Delegates actions on EMCRO. These were:

(1) That all final studies and conclusions of the EMCRO shall be submitted to the House of Delegates before any action is taken to make its programs operational; and

(2) That EMCRO forward to each county med-

ical society a detailed accounting of financial expenditures and a copy of the EMCRO grant continuation request.

Reports and Resolutions

Speaker Rogers then called for reports to be made by any officer or committee chairman on the matter of EMCRO.

David A. Wells, M.D., Dalton, chairman of Council, gave the following report:

CHAIRMAN OF COUNCIL

David A. Wells, M.D.

At its meeting in 1972, the House of Delegates directed that before any activities of the Georgia EMCRO become operational (as differentiated from being experimental) approval of the House of Delegates would be necessary.

The EMCRO annual report referred to the 1973 House of Delegates requested that the House delegate to the MAG Council the responsibility to review and approve EMCRO activities before being put into effect.

This request by EMCRO was based on the fact that its program would be adequately tested and ready for implementation during late fall of 1973 and should therefore not languish until the following 1974 Annual Session before its future disposition could be determined. Although the House of Delegates chose not to delegate responsibility for EMCRO, it did, nonetheless, see the necessity to come to a decision sufficiently in advance of the termination of federal funding as to allow EMCRO adequate time to get its program on a paying basis (or at least be moving in that direction). Accordingly, the Council was authorized to call a Special Session of the House of Delegates should it determinine "that timing is critical in making a decision about utilizing the methods as developed by EMCRO. . . ."

In addition the House also requested that a detailed financial report and a copy of the grant continuation request be sent to all county medical societies. Both of these requests have been accomplished.

Based on information given by EMCRO staff, the Executive Committee of Council voted to recommend to Council that a Special Session of the House of Delegates be called for December 15 to give the House an opportunity to evaluate the EMCRO program and make a subsequent decision as to whether or not EMCRO would be permitted to become an operational program.

Concurrent with this action, the Executive Committee also appointed an Ad Hoc Committee on EMCRO to function as a resource body for the presentation of all aspects of EMCRO at the Special Session of the House of Delegates. Dr. Ollie O. McGahee, of Jesup, was appointed chairman.

COUNCIL REPORT ON EMCRO

At the September meeting of Council, the Speaker of the House recommended a December 15 meeting of the House of Delegates. He stated that EMCRO must be operational by January 1, 1974 if it is to be able to build a sufficient base of participating hospitals by May 31, 1974 when EMCRO funding ceases. Their grant specifies that EMCRO will be operational during this year of funding which is its third year.

The purpose of this report is to detail the actions of the Council and the Executive Committee on EMCRO since the last meeting of the House in May 1973; and also to assure the members of the House that all recommendations on this subject have been fully complied with by Council, Executive Committee and staff.

RECOMMENDATION

Should the House of Delegates approve operational status for the EMCRO Program, it is recommended that the matter of the relationship of EMCRO to MAG be referred to the Committee on Reorganization and Structure for a report back to the House of Delegates at the 1974 meeting.

Speaker Rogers called for the introduction of resolutions and requested that the resolved portion only be read to the House. The following resolutions were presented:

RESOLUTION SS 73-5: EMCRO

Drs. W. J. Smith, E. A. Mayo and M. A. Glucksman, in behalf of the Glynn County Medical Society

WHEREAS, EMCRO has been proposed as a computerized record of patient care; and

WHEREAS, the data processed through EMCRO can be of inestimable value in monitoring mortality and morbidity rates and survival statistics in various disease processes; and

WHEREAS, it is the opinion of the Glynn County Medical Society that any program undertaken by organized medicine should have the improvement of the quality of patient care as a primary objective;

Now, therefore, BE IT RESOLVED, that EMCRO be expanded to provide statewide registries of tumors, trauma, cardiovascular and other diseases if and when financially feasible and that participating hospitals be provided with these tabulations as well as the reports envisioned in the original EMCRO program.

RESOLUTION SS 73-6: EMCRO

Robert W. Oliver, M.D., in behalf of the Laurens County Medical Society

WHEREAS, EMCRO or any method chosen to satisfy the requirements of Public Law 92-603 will place an additional financial burden on hospitals; and

WHEREAS, many hospitals in our state are already in severe financial straits; and

WHEREAS, the Cost of Living Council has been very strict in efforts to keep medical cost down; and

WHEREAS, EMCRO has been found to be one of the most economical methods available for chart review;

NOW, BE IT RESOLVED, that the Medical Association of Georgia go on record as being in favor of allowing local hospitals to increase their charges to cover these expenses and that the Cost of Living Council be made aware of this recommendation.

Report of the Committee on EMCRO

Speaker Rogers then called for the report of the

Ad Hoc Committee on EMCRO to be given by Ollie O. McGahee, M.D., Jesup, chairman.

AD HOC COMMITTEE ON EMCRO

Ollie O. McGahee, Jr., M.D.

The EMCRO (Experimental Medical Care Review Organization) is a project of the Medical Association of Georgia and is funded by the National Center for Health Services Research and Development. Of particular interest is the EMCRO Hospital Discharge Astract System whose purpose is to aid hospital medical staffs in conducting medical audit and utilization review. It functions by processing abstracts of the medical records of all participating hospitals and comparing them to criteria developed by the state specialty societies. Reports of exceptions to those criteria are then returned to the medical staffs of those hospitals for review. The system is designed to meet audit requirements of the Joint Commission on Accreditation of Hospitals, and to serve as the basis for medical staff audit that may allow a hospital to conduct its own review in lieu of PSRO review. Participation in this system is entirely voluntary.

EMCRO is an important effort by the physicians of Georgia to develop a system to meet their own needs, and represents a significant opportunity for medical staffs to implement an effective system of quality assurance. The increased involvement and input of Georgia physicians is essential to the success of this effort.

HOSPITAL SUB-COMMITTEE

The Hospital Program Sub-Committee began its study by comparing IMAGE (the Georgia EMCRO Hospital Discharge Abstract System) with other computerized data systems which are available to Georgia hospitals. IMAGE (Information for Medical Audit by the Generation of Exceptions) is designed to help meet audit and statistical requirements of the Joint Commission on Accreditation of Hospitals and other accrediting agencies. It serves as a basis for an objective in-house system of medical review. Such a system, if seen as effective by the Professional Standards Review Organization (PSRO), may aid the hospitals in conducting its own review in lieu of PSRO scrutiny of individual claims.

All data systems reviewed collect the same basic patient data: patient chart number, data of admission, date of discharge, diagnosis and surgical codes, etc. To satisfy requirements of retrospective review, the EMCRO hospital program has, within the computer, screening parameters for over one hundred diagnoses and surgical procedures. These parameters were developed by panels of Georgia physicians. The parameters will be modified by the specialty panels as they review the results of the field test, and on a regular basis thereafter. It is the only data system reviewed which includes screening parameters as an integral part of the system. Many other systems do not collect, on a regular basis, the clinical information necessary for ongoing review.

It is felt that the support provided by IMAGE staff to participating hospitals is one of the most important advantages of the system. An extensive training period for the medical record department of a hospital provides instruction in abstracting and coding, identification of laboratory tests on the abstract, and suggestion of procedures to facilitate the abstracting process. During the training period, the IMAGE health record analyst and nurse work with the medical record administrator, pathologist, and abstractors of the hospital, as well as other appropriate personnel. They follow the initial training period by a later visit to retrain in specific areas, if necessary, and to answer questions. A WATS line has been installed for the convenience of participating hospitals.

An IMAGE health record analyst is available to provide instruction in the analysis and effective use of reports for the review of medical care by the medical staff. Training courses for the hospital health record analyst will be provided so she will be able to effectively assist the medical staff in the retrieval of information and utilization of the reports.

From the information collected on the abstracts, reports are generated for the utilization by committes of the hospital medical staff. Continuing education committees can utilize the EMCRO Hospital Discharge Abstract System reports to select and structure their continuing education programs based on identified need.

IMAGE is an economically feasible data retrieval system, at least comparable to other available systems. In addition, it includes screening parameters developed by panels of Georgia physicians and surgeons. These parameters are flexible and will be modified on a continuing basis. Quality control and an easily usable data display are built into the system. It is recognized that this system will be only part of Medical Audit and may not be chosen by every hospital in Georgia, but it is recommended that the Medical Association of Georgia continue its support.

CRITERIA SUB-COMMITTEE

This sub-committee reviewed both the method of criteria development employed by the EMCRO and the type of criteria utilized in the review system.

The 100 criteria were developed by specialty panels of physicians selected by the presidents of the state specialty societies. It is the view of this sub-committee, and of the panels themselves, that the state specialty societies are the most appropriate authors of criteria to be utilized on a statewide basis. This is, in part, due to the relationship between criteria for evaluation of quality and the specialty societies' responsibility for conducting scientific programs.

The criteria are utilized as "screens" by EMCRO, though a hospital medical staff may wish to adopt them as their criteria or make modification to them for use in their hospital. Medical staffs of participating hospitals are encouraged to submit their recommendations for criteria modifications to the chairman of the state specialty panels.

Indications for admission or surgery are included in the criteria as an aid to the medical staffs, though they are not employed as screens by EMCRO. Criteria employed as screens include those diagnostic and therapeutic services "critical to high quality care" and "consistent with the diagnosis." "Critical" services are those which, generally speaking, should be provided to essentially all patients admitted for treatment of the given diagnosis. "Consistent" services are those which should occasionally be provided to patients admitted for treatment of the given diagnosis. Suggested lengths of stay were also developed by the specialty panels.

A number of criteria are already in need of modifi-



cation: some diagnoses need to be more clearly defined, there are inconsistencies, as well as some logical errors, etc. The importance of physician commitment to the development of medically sound criteria cannot be overemphasized.

To date, the criteria developed have been essentially those of "process"—looking at what services are provided the patient. This approach considers the question of whether the patient received all services critical to his care, as well as the question of whether any unnecessary or contraindicated services were provided. Process measures are necessary to utilization review and are included in the JCAH requirements for documentation of a hospital's review activities.

Process information may be abstracted from the medical record readily, requiring little or no interpretation by medical record personnel. Review of process may be ongoing and encompass all diseases for which criteria have been developed.

A more difficult area to measure is "outcomes"—how the patient fares. Data will be returned to the specialty panels in the spring to assist them in developing these measures. For each diagnosis for which criteria have been developed, information as to the percentage of patients who developed complications will be displayed. Each complication will be identified. It is expected that percentage points will be established for each complication as outcomes screens to be included in the review criteria. Mortality data will also be provided these panels. These outcomes, however, are only intermediate ones—measured during the hospital stay.

Participating hospitals will be able to conduct more sophisticated outcomes measurements should they desire to do so. Health record analysts may perform the necessary patient follow-up. The medical record department may wish to calculate readmission rate, etc. These medical staffs may wish to inform the specialty panels of the results of these special studies. It is only through efforts such as these that the EMCRO criteria will be truly validated. Large statistical populations are required to make these judgements, and the specialty panels will need to encourage the cooperation of a number of medical staffs.

NURSING HOME SUB-COMMITTEE

CARE, Centralized Abstract Review, EMCRO's system of centralized utilization and quality review for nursing homes, will conclude the second of two extensive periods of field-testing December 31, 1973. CARE applies, by computer, criteria for appropriateness of level of care and criteria for quality of care to abstracts of the medical records of patients in all participating nursing homes. Reports will then be generated for return to the nursing homes themselves as well as to a review board who will make the actual determinations of appropriate skill level, etc.

The criteria for quality and for skill level have been developed over the last 12 months by MAG's Committee on Geriatric Medicine which includes four nursing home administrators and the following physicians: Joseph S. Wilson, M.D., chairman; Carl C. Aven, M.D.; William Futch, M.D.; Ralph A. Murphy, Jr., M.D.; Joe D. Rawlings, M.D.; Donald J. Welter, M.D.; Bernard H. Palay, M.D.; Joe S. Cruise, M.D.; George Green, M.D.; and Joseph Pacifici, M.D. This committee, augmented by other health professionals, will function as the review board as well.

MAG's Committee on Geriatric Medicine, as well as the Georgia Nursing Home Association, expect the abstract developed by CARE to replace: (1) the MA1.6 form required by the Department of Human Resources, (2) the pre-admission form required by the Georgia Medical Care Foundation, (3) the on-site review form required by the Georgia Medical Care Foundation, and (4) the utilization review forms of the nursing homes themselves. Elimination of considerable paperwork and duplication of effort will be achieved by this action.

CARE collects the following data on its abstract: sociological and statistical information, diagnoses and conditions, mental and behaviorial status, severity of impairments, patient's ability to perform activities of daily living, diagnostic procedures done, medications and treatments administered, restorative services provided, the patient's overall condition and restorative potential.

From this data is generated the necessary reports including those required of nursing homes accredited by JCAH, as well as management reports for the administrator. The system also has the capability of generating claims.

When prepared by a hospital discharge planning nurse, the abstract not only expedites admission to an appropriate nursing care facility, but provides needed medical and nursing information rarely available to the

nursing home staff, thereby facilitating maintenance of continuity of care.

The cost of the system is approximately $10 per bed per year for participating nursing homes. The system is voluntary and would be financially supported by the homes themselves.

CARE has been judged to be the nation's most advanced system of automated nursing home review by Arthur D. Little, Inc., consultants to the National Center for Health Services Research and Development.

CONFIDENTIALITY SUB-COMMITTEE

The general feeling of this sub-committee is that the confidentiality of medical information in computerized data collection systems is best safeguarded when such data collection systems are operated by organized medicine.

Confidentiality of such information within MAG is a function of MAG's Committee on the Protection of Human Subjects whose members are: Mrs. Eva Galambos, Ph.D., Robert J. Van De Wetering, M.D., Charles R. Underwood, M.D. and Edward R. Uehling, M.D. This committee has established the procedures utilized by EMCRO in assuring data confidentiality. These procedures include: (1) the requirement that reports contain no patient or physician names—only the identification number coded on the abstracts, (2) the requirement that no report in which a facility is identified may be released without written authorization from the facility, (3) the requirement that any statistical report authorized for release by the Committee for the Protection of Human Subjects include only the data essential to the requesting organization's needs.

On the EMCRO hospital abstract, physician and patient identity are coded within the hospital medical record department utilizing codes unique to that hospital. EMCRO does not have access to these codes. The EMCRO reports are returned to the medical record department for review by the medical staff which may, of course, decode the identities.

In the case of the nursing home abstract, the patient identification will be by a number assigned by the facility or (in the case of Medicaid and Medicare patients) the third-party payor. The latter provision is necessary if one abstract is to replace the four currently in use. The physician's license number will likely be required as well, if this abstract is to perform the preadmission certification function.

This sub-committee feels that the release of statistical information of value to physicians will benefit patient care, and is an important function of MAG's data collection system.

FINANCE SUB-COMMITTEE

The sub-committee on finance submits its report in two parts: (a) a report of expenditures to date by the EMCRO, and (b) a report of anticipated future expenses by hospitals participating in EMCRO.

As a preliminary to this report, we would like to say that we believe the following are the objectives of EMCRO: (1) to help hospitals and physicians assess the quality of care in hospitals and nursing homes; (2) to assist in medical audit and utilization review procedures; (3) to contribute information to be used in continuing educations programs; and (4) to offer a means of affecting some control over the rising costs of medical care.

In a financial analysis of any program of medical audit, it would seem to be singularly important in the light of objective 4, that the cost of the anticipated program of medical care review would actually not contribute to an increase to the total cost of medical care.

A. Expenditures to Date

Delegates have previously been furnished with a breakdown of financial expenditures by EMCRO for fiscal year ending 5/31/72, 5/31/73, and 5/31/74. A more detailed discussion of these expenditures may be undertaken when the House of Delegates convenes if this is necessary. Suffice to say that the expenditures have been appropriately discussed, audited and verified.

Fiscal year ending 5/31/72—expenditures of $46,-951.47: these expenditures were primarily utilized in developing the initial grant application for federal funding for the Experimental Medical Care Review Organization in Georgia.

Fiscal year ending 5/31/73—total expenditures of $239,456.35: expenditures during this year were devoted to developing the discharge summary abstract for hospitals and the nursing home data abstract systems. Further expenditures were devoted to developing the criteria for the one hundred diagnoses that are now available for usage in audit.

Expenditures through November 30, 1973—$94,-017.99: primarily devoted to further criteria development and to becoming operational on an experimental basis in the initial four hospitals utilized.

Fiscal year ending 5/31/74—budgeted expenditures of $299,072.

Total expenditures of $380,425.81 through November 30, 1973, to develop the system as available to date.

Anticipated expenditures of $585,479.82 through May 31, 1974.

The program to date has been totally funded through the federal grant. It should be pointed out that thousands of physician man hours have been contributed on a no-cost basis, primarily in the area of criteria development. It is obvious that the largest portion of the expenditures to date have been involved in personnel salaries, with the second greatest expenditure being in the area of computer consultation and computer time.

B. Anticipated Future Expenses for Involved Hospitals

1. Out of hospital expenses: $.75 per discharge abstract payable to EMCRO. This cost estimate is based on a volume of 352,000 discharges in 1974, and 800,-000 discharges in 1975. This volume is dependent on starting on January 1, 1974, with 17 hospitals in the system and consistently adding five more hospitals each month. The $.75 per discharge abstract would be a stable price only if the anticipated volume is met. The cost could escalate considerably should this growth factor not be realized.

2. In-hospital costs: The EMCRO accountant estimates that these will range in the area of $10,000 annually for a normal, 200-bed institution. This is to include in-hospital abstracting of discharge records for submission to EMCRO and physician review time. Time cost studies to date would indicate that one abstractor, working a 7½ hour day, at a cost of $3.50 per hour, abstracting one record every 10 minutes, resulted in 40 completed abstracts per day, with a resultant cost of approximately $.66 per abstract. At this rate 10,400 abstracts per year would be completed with a hospital

personnel cost of $.66 plus $.75 EMCRO charges or $1.41 per hospital abstract.

3. Further cost to be estimated: (1) Training of personnel as abstractors. (2) Change-over from I-CDA-8 coding to H-ICDA coding as utilized by EMCRO. (3) Training and salaries for health record analysts. EMCRO would train these persons at a cost of $250 per week for training. These personnel would have the responsibility of analyzing reports submitted by EMCRO on the basis of review of abstract summaries. The health record analyst would then disseminate this information as indicated to hospital administrators, audit committees, utilization committees and continuing education committees for appropriate use. (4) Physician training and physician review time. (5) Physician continuing education as a result of information obtained from medical care review audit.

On the basis of these projected costs, it would therefore be estimated that a hospital generating 10,000 discharge abstracts per year would have an expense of $7,500 per year to EMCRO, $6,600 per year in-hospital personnel costs for abstractors, or $14,100 per year per 10,000 discharge abstracts plus additional costs of training health record analysts, and physician time and physician continuing education programs.

RECOMMENDATION:

This committee recommends that EMCRO be permitted to go operational January 1, 1974, realizing that the system is not fully developed and needs some modification but *may have* significant potential to aid hospital medical staffs in the performance of local review and medical audit. EMCRO may also have significant potential to aid nursing homes in determining quality of care and appropriateness of level of care. It is further recommended that this Ad Hoc Committee on EMCRO be continued, and that it regularly report to the House of Delegates.

EMCRO FINANCIAL EXPENDITURES
(Fiscal Year Ending 5/31/72)

			Actual	*Budget*
1. Personnel				
Salaries	$17,050.17			
Fringe Benefits	1,388.30			
			$18,438.47	$22,100.00
2. Consultant Services				
Computer	$ 7,620.00			
Criteria Development	2,465.29			
			$10,085.29	$10,500.00
3. Equipment				
Office Equipment	$ 520.00			
Office Furniture	1,698.79			
			$ 2,218.79	$ 2,300.00
4. Supplies				
Office Supplies	$ 350.00			
Duplicating Supplies	71.12			
			$ 421.12	$ 500.00
5. Travel				
In-State				
Criteria Development	$ 1,094.51			
Administrative	600.00			
Out-State				
Conferences	$ 640.00			
			$ 2,334.52	$ 2,800.00
6. Alteration & Renovations				$ 1,100.00
7. Other*				
E.D.P. Services			$ 9,570.18	$10,000.00
Postage			$ 68.46	$ 150.00
Xerox			$ 594.59	$ 250.00
Telephone			$ 667.71	$ 300.00
			$44,399.12	$50,000.00
Indirect Cost			2,552.35	2,769.00
Totals			$46,951.47	$52,769.00

EMCRO FINANCIAL EXPENDITURES
(Fiscal Year Ending 5/31/73)

			Actual	*Budget*
1. Personnel				
Salaries	$109,853.69			
Fringe Benefits	8,250.76			
			$118,104.45	$138,256.00
2. Consultant Services				
Pharmacy	$ 1,652.88			
Computer	8,950.45			
Criteria Development	3,516.62			
Medical Records	1,092.60			
			$ 15,212.55	$ 21,834.00
3. Equipment				
Office Equipment	$ 5,377.09			
Office Furniture	8,772.76			
			$ 14,149.85	$ 15,400.00
4. Supplies				
Office Supplies	$ 4,200.00			
Duplicating Supplies	2,800.00			
Visual Aid Supplies	67.27			
			$ 7,067.27	$ 12,010.00
5. Travel				
In-State				
Training	$ 1,000.00			
Criteria Development	9,165.84			
Administrative	2,019.31			
Out-State				
Training	$ 1,680.00			
Conferences	3,794.49			
			$ 17,659.64	$ 19,750.00
6. Other*				
E.D.P Services			$ 37,906.68	$ 44,000.00
Postage			$ 648.79	$ 1,200.00
Publications			$ 2,559.69	$ 3,000.00
Auditing				$ 500.00
Printing				
Hospital Program	$ 464.70			
Nursing Home Program	390.00			
Criteria	300.00			
Visual Aids, Forms, Etc.	107.06			
			$ 1,161.76	$ 1,500.00
Registration Fees			$ 2,509.00	$ 2,500.00
Telephone			$ 4,790.23	$ 6,650.00
			$221,769.91	$266,000.00
Indirect Cost			17,686.44	22,014.00
Totals			$239,456.35	$288,014.00

* Funds are re-allocatable among the sub-categories.

EMCRO FINANCIAL EXPENDITURES
(Fiscal Year Ending 5/31/74)

		Actual (Thru Nov. 30, 1973)	*Budget*
1. Personnel			
Salaries	$39,173.55		
Fringe	7,652.51		
		$ 46,826.06	$ 96,541.00
2. Consultants			
Pharmacy	$ 2,310.00		
Computer	715.42		
Criteria Development	248.00		
Medical Records	360.08		
		$ 3,633.50	$ 20,000.00
3. Equipment			
Office Equipment	$ 767.97		
Office Furniture	607.91		
		$ 1,375.88	$ 7,250.00
4. Supplies			
Office Supplies	$ 1,849.95		
Duplicating Services	4,911.67		
Visual Aid Supplies	88.25		
		$ 6,849.87	$ 16,000.00
5. Travel			
In-State			
Training	$ 6,439.91		
Criteria Development	2,191.92		
Adminis-trative	282.12		
Out-State			
Training	$ 5,485,21		
Conferences	1,730.97		
		$ 16,096.09	$ 28,000.00
6. Other			
E.D.P. Services			$ 85,734.00
Postage		$ 643.77	$ 2,500.00
Publications		$ 1,940.79	$ 3,500.00
Printing			
Hospital Program	$ 1,735.76		
Nursing Home Program	725.10		
Criteria	1,086.22		
Visual Aids, Forms, Etc.	181.27		
		$ 3,728.35	$ 6,500.00
Registration Fees		$ 2,729.25	$ 4,500.00
Telephone		$ 3,240.13	$ 9,000.00
Equipment Lease		$ 127.40	$ 4,800.00
		$87,191.09	$284,325.00
Indirect Cost		6,826.90	14,747.00
Totals		$94,017.99	$299,072.00

At the conclusion of the committee report given by Dr. McGahee, Speaker Rogers introduced to the House all members of the Ad Hoc Committee on EMCRO, as follows:

Ollie O. McGahee, Jesup, chairman; W. Upton Clary, Savannah; John I. Dickerson, Rome; John R. McCain, Atlanta; Charles E. Todd, Atlanta; LaMar S. McGinnis, DeKalb County; Donald J. McKenzie, Thomasville; D. R. Mahan, Dalton; Jack A. Raines, Columbus; Robert B. Copeland, La-Grange; Joseph M. Turner, Tifton; R. H. Vaughan, Columbus; Thomas E. Whitesides, Atlanta; J. S. Wilson, Atlanta; and Ellis B. Keener, Decatur.

With these introductions, the Speaker announced that the floor was now opened for discussion of the EMCRO project. He advised further that the pending business before the House consisted of the report of the Chairman of Council, the report of the Ad Hoc Committee on EMCRO and Resolutions SS 73-5 and SS 73-6.

At the conclusion of debate, the following actions pertaining to EMCRO were adopted:

(1) **Chairman of Council Report:** "Should the House of Delegates approve operational status for the EMCRO program, it is recommended that the matter of the relationship of EMCRO to MAG be referred to the Committee on Reorganization and Structure for a report back to the House of Delegates at its 1974 meeting."

(2) **EMCRO Committee Report:** This committee recommends that EMCRO be permitted to go operational January 1, 1974, realizing that the system is not fully developed and needs some modifications but may have significant potential to aid hospital medical staffs in the performance of local review and medical audit. EMCRO may also have significant potential to aid nursing homes in determining quality of care and appropriateness of level of care. It is further recommended that this ad hoc committee on EMCRO be continued and that it regularly report to the MAG Executive Committee of Council and to the House of Delegates: and that this committee be highly commended for the job it has done. In addition the House resolved that no funds derived from MAG membership dues or assessments be expended for the operation, administration or overhead of EMCRO."

(3) **Resolution SS 73-5:** "Be it resolved that EMCRO be expanded to provide statewise registries of tumors, trauma, cardiovascular and other diseases, if and when financially feasible, and that participating hospitals be provided with these tabulations as well as the reports envisioned in the original EMCRO report.

(4) **Resolution SS 73-6:** "Be it resolved that Medical Association of Georgia go on record as being in favor of allowing local hospitals to increase their charges to cover these expenses (those identified in Resolution SS73-6) and that the Cost of Living Council will be made aware of this recommendation."

(5) In addition the House resolved (Kaufmann—MAA Amendment to Committee Report) that in order to have EMCRO distinctive and physician-oriented that future efforts be directed to identifying deficiencies as to whether they are physician, administrative, hospital, nursing home, nursing, laboratory or ancillary service-related; and that the main future thrust of EMCRO be directed to the determination of the outcome of the patient, both short and long term as this is the real evaluation of quality care.

At this point the EMCRO portion of the Special Session of the House of Delegates was concluded and the Speaker called for a 15 minute recess prior

to commencing consideration of Professional Standards Review Organization.

PSRO

The second portion of the Special Session of the House of Delegates of the Medical Association of Georgia was called to order at 3:25 p.m. by Speaker Harrison L. Rogers, Jr., M.D., Atlanta, in the North Ballroom, Marriott Motor Hotel, Atlanta, Georgia.

The Chair ruled that the motion adopted previously regarding "informal consideration" was still in effect and would guide consideration of PSRO by the House of Delegates.

The Speaker briefly reviewed the essence of the action taken by the House of Delegates at the meeting in May 1973 and by the MAG Council in meeting September 1973 on PSRO as follows:

(1) Work to modify and improve the present PSRO law;

(2) Continue to study procedures to implement PSRO and offer constructive input;

(3) Make regular reports to the county medical societies regarding PSRO development;

(4) Enter into no contractual arrangement without previously referring the matter to the House of Delegates;

(5) Send copy of the House action (resolution) to all 50 state medical associations;

(6) Present the matter to AMA House of Delegates at the June 1973 meeting.

Council took the following action:

(1) Voted to include PSRO in the official call of this special meeting of the House of Delegates and

(2) Stipulated that the matter may be included for informational or educational purposes only.

The Chair then ruled that the action of the House of Delegates and Council did not require this House of Delegates to take any definitive stand for or against participation in PSRO.

Reports and Resolutions

The Speaker then called for reports on PSRO to be made by any officer or committee chairman, and at that point asked David A. Wells, M.D., Dalton, chairman of Council, to make his report.

CHAIRMAN OF COUNCIL

David A. Wells, M.D.

The Council of the Medical Association of Georgia has been aware of PSRO Legislation from its very inception over three years ago. At the September meeting of Council in 1970, a discussion of the Bennett Amendment occurred which included comments on several reservations about its content. Although



Ed Evans makes a point before the Medical Association of Atlanta luncheon caucus, one of several "half time" conferences held by county societies during Saturday's session.

MAG approved the intent of the Amendment, a letter expressing our concern over several portions of the Amendment was sent to Senator Talmadge as a member of the Finance Committee which was considering PSRO.

No further definitive action was taken by your Council, since, for the most part, the Georgia Medical Care Foundation was functioning in the capacity of a PSRO-like organization for the Medicaid program starting in July of 1971.

Then, at the December Council meeting of 1972, the MAG staff was instructed to evaluate areas around the state which had the capability of engaging in PSRO-like activities and which were interested in working toward organizing such a structure through the Georgia Medical Care Foundation. The only area which undertook such an activity is metropolitan Atlanta which has an on-going medical care foundation function which includes several programs including a sub-contract from the Georgia Medical Care Foundation for review of Medicaid and Blue Shield of Atlanta.

In March of 1973 your Council recommended that physicians from around the state be brought together to discuss PSRO area designation and that the county medical societies be contacted concerning their desires for inclusion in a particular review area. This action culminated in the MAG sponsored PSRO Conference in Macon in April and then the development of the MAG PSRO area plan with its local and regional review areas. This geographical area plan was completed after contact with all of the county medical societies by letter as well as a meeting with a number of their representatives at a meeting preceding the MAG House of Delegates.

In May of 1973 at the Council meeting preceding the meeting of the House of Delegates, Council was advised of the Executive Committee's action to instruct MAG legal counsel to draw up language to form a Professional Standards Review Organization of Georgia. At that time no action was taken to incorporate the PSROG since the MAG House House of Delegates was expected to act on PSRO.

In August of 1973, the MAG Executive Committee of Council acted to incorporate the PSROG in order to reinforce its decision to work for a single state-wide PSRO. This action was taken to insure that organized medicine maintained as much control as possible under the law. No further action was taken to organize the

PSROG nor will any further action be taken until the House so directs. No directors have been named nor any organizational meeting called. The sole intent of Executive Committee was not to circumvent the House adopted resolution on PSRO but to strengthen MAG's case for a single PSRO in Georgia.

You are all aware of the action taken by this House of Delegates at its meeting in May of 1973 regarding PSRO. The House specifically required that another meeting of the House of Delegates be called for consideration of any contract proposals between the MAG or any of its subsidiary organizations and HEW for PSRO. Although such an occasion has not arisen, at the September meeting of Council in 1973, based on a recommendation from the MAG Committee on PSRO, Council voted to hold a special called meeting of the MAG House of Delegates for consideration of PSRO if only for informational or educational purposes in conjunction with a special called meeting for consideration of making EMCRO operational.

In order to assure that your elected Officers are appropriately carrying out the wishes of the membership as expressed by this House of Delegates, I would make the recommendations listed below for your consideration. Bear in mind that these recommendations are not an endorsement of PSRO but only represent what appears to be the most favorable posture for MAG at this time.

RECOMMENDATIONS:

Endorsement of the concept of a state wide PSRO area with regional PSRO areas and local peer review organizations.

Support for the Professional Standards Review Organization of Georgia as MAG's single state-wide agency for designation by HEW as the PSRO for Georgia.

Referral to the MAG Committee on PSRO the continued study of the PSRO law, the MAG plan for implementation of PSRO, and requirement that the Committee report again to this House of Delegates in May on its findings.

Authorize Council to call, if it deems necessary, this House into session for an additional day in May of 1974, in conjunction with the Annual Meeting of the House of Delegates, to consider the single question of PSRO.

Speaker Rogers then called for the introduction of resolutions and requested that the delegate presenting the resolution read only the "Be it resolved" portion. Accordingly the following resolutions were offered:

RESOLUTION SS 73-1: PSRO

Charles McDowell, M.D., in behalf of the DeKalb County Medical Society

WHEREAS, there are many Georgia physicians who advocate nonparticipation with the PSRO law and many others who support implementation; and

WHEREAS, there appears to be a uniform agreement among all these physicians that PSRO is a bad law as it is unworkable, fiscally impractical, incompatible with good medical care, restrictive to the doctor-patient relationship, invades the confidentiality of a patient's medical records and adversely affects the excellent system of health care delivery that we now have; therefore be it

RESOLVED, that the Medical Association of Georgia, through its Council and appropriately designated committees, work diligently for the repeal of PSRO law; and be it further

RESOLVED, that a program be implemented to inform physicians, patients, and lawmakers regarding the deleterious facets of the law as soon as possible; and be it further

RESOLVED, that other appropriate programs be developed and implemented to enhance the efforts to repeal the law; and be it further

RESOLVED, that substantial funds be appropriated from MAG to subsidize these programs, with a request to the American Medical Association for matching funds, and be it further

RESOLVED, that a progress report be presented to the MAG House of Delegates at its annual session in May, 1974; and be it further

RESOLVED, that a copy of this resolution be forwarded to the American Medical Association, all state medical associations, metropolitan county medical societies, and the members of the Georgia Congressional delegation.

RESOLUTION SS 73-2: PSRO

Richard E. Thompson, M.D., in behalf of the Muscogee County Medical Society

WHEREAS, PSRO functions are quality care and cost containment; and

WHEREAS, the Muscogee County Medical Society appreciates that the medical care audit system is the crux of PSRO actions and decisions and therefore must be medically sound, now therefore be it

RESOLVED, that we approve of any audit system which a) includes outcome criteria, b) acknowledges and allows for variations in treatment methods by which maximum patient outcome at reasonable cost may be achieved and c) provides for identification of the health provider responsible for "deficiencies" (hospital, physician, patient, or other).

RESOLUTION SS 73-3: PSRO

Luther M. Thomas, Jr., M.D., in behalf of the Richmond County Medical Society

BE IT RESOLVED, that the Richmond County Medical Society urgently request our American Medical Association Delegates to seek and support the American Medical Association efforts to repeal Professional Standards Review Organizations, and that the Richmond County Medical Society delegates to the Medical Association of Georgia meeting of December 15, 1973 be also urgently requested to seek and support Medical Association of Georgia efforts to repeal Professional Standards Review Organizations.

RESOLUTION SS 73-4: PSRO

John Pierce Tucker, M.D., in behalf of the Colquitt County Medical Society

BE IT HEREBY RESOLVED, that the House of Delegates cast their vote in favor of repeal of PSRO legislation.

American Medical Association Report

Speaker Rogers called on John S. Atwater, M.D., Atlanta, acting chairman of the MAG delegation to the AMA House of Delegates for a report on the AMA Clinical Convention held in Anaheim, California, December 1-5, 1973. Dr. Atwater gave an informational report with specific reference to PSRO activities at a pre-convention meeting in Anaheim in Reference Committee on the floor of the House of Delegates.

PSRO Committee Report

The Speaker next called for the report of the Committee on PSRO which was given jointly by Charles Hollis, M.D., Albany, chairman, and John Heard, M.D., Decatur, vice-chairman.

MAG COMMITTEE ON PSRO

Charles D. Hollis, Jr., M.D., Chairman

OUTLINE OF REPORT

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   B. Activity
II. Development of PSRO legislation in Congress
   A. AMA activity
III. Summary of PSRO law
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   B. Structure and Organization: Charles D. Hollis, M.D., Thomas G. Douglass, M.D., L. T. Crimmins, M.D.
   C. Data collection, processing, storage and computers: Joseph M. Almand, M.D., James H. Sullivan, M.D.
   D. Program Evaluation: James J. Oosterhoudt, M.D., James A. Kaufmann, M.D.
   E. Communications and Education: Louis Felder, M.D., R. D. Walter, M.D.
   F. Costs: John P. Heard, M.D., Charles W. McDowell, Jr., M.D.
   G. Alternatives: W. Dan Jordan, M.D., J. K. Quattlebaum, Jr., M.D.
VII. Options of MAG
VIII. Committee Recommendations
   1. Work for repeal of law
   2. No implementation by MAG
   3. Oppose implementation by unrepresentative groups
   4. Continue study of PSRO law
   5. Develop alternate plan
   6. Educational program for public and legislators
   7. Support peer review studies
   8. Encourage hospital level review
   9. Liaison with other state medical societies
   10. Approve AMA House of Delegates action

I. Background of Committee

At the Annual Session in May, 1973, the House of Delegates of MAG voted to take no action on PSRO, and to instruct all branches of the Association to enter into no contract regarding PSRO until so instructed by the House of Delegates. In the meantime, the House expressed its displeasure with the law, but elected to study the law so as to be better informed.

With this in mind, the MAG Executive Committee appointed a PSRO Study Committee which immediately selected the following objectives:

(1) Seek information concerning PSRO which would be helpful to MAG.

(2) Inform MAG members about the significant impact of PSRO on their practices.

(3) Educate the public about the potentially destructive force PSRO would have on the private practice of medicine.

(4) Communicate with our Congressional Delegation about the disadvantages of PSRO and investigate the possibility of its repeal.

(5) Inform the AMA and other state medical associations of our actions so we could present a united front.

The committee has spent most of its time on research and study in an effort to learn more about the full impact of the law. It hopes now to inform the membership through this meeting and through follow-up committee meetings about the facts of the law and its far reaching ramifications.

Your committee of 16 members from all over the state has met five times. It represents varied philosophies and opinions about appropriate response of organized medicine to the PSRO law. In this rather lengthy report an effort has been made to relay to the House the basic facts learned, to describe the serious problems which might be anticipated if it is to function as designed, and to recommend from the majority of this group a feeling of how MAG should proceed. It does not express the exact viewpoint of the chairman or any other single member of the committee.

The general feeling as expressed by most of the members of the committee is that PSRO is not a good law. It represents the most significant legislation ever passed as far as its potential effect on the practicing physician and the medical delivery system are concerned. "The practice of medicine will be revolutionized," it was stated in Anaheim at the AMA Clinical meeting. It has been revealed that most physicians know very little about the details of the law. Some are concerned and alarmed but a majority are rather apathetic. There is much to suggest that the practicing physician is not sufficiently aroused to reverse the potential thrust of the law, a thrust which could result in destructive effects on the present health care system.

II. Development of PSRO Legislation

We would like to explain at this point, that the so-called PSRO law is Sec. 249-F of Public Law 92-603 passed a little over a year ago. Public Law 92-603

originated in the House of Representatives as HR-1, Amendments to the Social Security Law.

The PSRO Section was added in the Senate Finance Committee as the "Bennett Amendment," introduced by Sen. Wallace Bennett, R-Utah. Its stated purpose is to insure quality health care in the most economical manner to those recipients of benefits under Medicare, Medicaid and Maternal and Child Health programs.

The differences in the House and Senate revisions of HR-1 were then ironed out in a joint Senate-House Conference Committee. This joint revision was then passed hurriedly as a last minute item in both houses, without discussion, and no debate.

Because of the mechanism used to attach the Bennett Amendment as a rider to the original House bill, PSRO was never debated in the House. Congressmen themselves say that a vast majority of the members voted on the almost 1,000 page HR-1 as a whole, being unaware of the PSRO Section.

The AMA opposed the Bennett Amendment in the Senate unsuccessfully, and made no attempt to inform the House of its presence. But the AMA opposition was tempered by the fact that there had been a similar proposal, Professional Review Organizations (PRO), which has subsequently been removed in the Medicredit Bill AMA is sponsoring for National Health Insurance. Many feel that this fact destroyed the effectiveness of the AMA testimony in opposition to PSRO.

III. Summary of the PSRO Law

(1) This is a skeleton law only. The implementation of it will be directed through detailed guidelines formulated by the Department of HEW.

(2) Senator Herman Talmadge, chairman of the subcommittee on Health of the Finance Committee, the most influential position on health matters in the Senate, is in favor of the PSRO concept.

(3) PSRO area designations by the Secretary of HEW will have to be completed by January 1, 1974. Even though the size of the areas is not specified in the law, a guideline from the Department of HEW suggests that no area should include a physician population of less than 300 nor more than 2500. This limit of 2500 is perhaps not absolute. HEW has implied that 25 states will be awarded statewide designation and 25 will have two or more area designations within the state. Georgia is not one of the 25 smaller states and the probable outcome will be that Georgia will have three areas designated. Organized medical groups violently disagree with this directive from HEW and feel that areas should be designated on a statewide basis. This would allow one central group, probably an arm of the state medical society, to contract with HEW and administer the required functions for all physicians in the state.

(4) Between 1974 and 1976 a group of physicians and osteopaths, perhaps a subsidiary corporation of a district medical society or a medical care foundation, within each designated area can apply as a PSRO organization. It is possible for a group of physicians of any size to make application. Once the application has been made, HEW will allocate funds and send administrative help in setting up the review procedures. Should 10 per cent of the practicing physicians be unable to agree that the applicant is a representative group, this 10 per cent minority can then request that all physicians in the area be canvassed. The majority of the physicians voting in the area will determine whether or not the organization designated should be allowed to function.

(5) In states with three or more areas there will be a state-wide PSRO council composed of one member from each PSRO, two physicians appointed by the state medical society, two physicians appointed by the state hospital association and four non-physician members to represent the public. This statewide council will coordinate and supervise the activities of the several PSRO organizations within its state. If three or four PSRO areas are represented on the council, there will be a predominance of non-physician representation. With two or less areas there would be no council; with five or more areas, physicians would be in a majority on the council. In the larger states with multiple areas, it has been suggested that there be a statewide advisory group of physicians, tentatively to be called the medical resource center for the state.

(6) Norms and standards of care and the average duration of treatment for various diseases will be established. Eight task forces from AMA representing the major specialty societies are in process of developing these. Local PSRO organizations will have the option of modifying the norms and standards with approval of the National PSRO council and the HEW. All hospital and nursing home cases will be studied and compared with the norms by computer to be sure that their treatment falls within acceptable limits.

(7) The review process will be designated so that the initial review will be done primarily by non-physician personnel. Data will be extracted from the record and submitted to the computer. If the care administered to the patient, either in "process" or duration, deviates from the norms, the case will be referred to a physician committee for further evaluation. Should it be determined that the care was unnecessary, was rendered in the hospital when it could have been offered on an ambulatory basis, was inferior in quality, or unusually expensive, the bill will not be paid. For violations one of three things can result:

(a) the physician will be called in and warned that his care in some way deviated from acceptable standards and norms;

(b) the physician can be required to pay the bill or a fine up to a maximum of $5,000 and a public disclosure made of the decision;

(c) the physician, for repeated violations, can be banned from reimbursement for treatment of patients covered under the Social Security Act.

(8) In order to reach its decisions, the PSRO will have access not only to records of patients whose care is paid for by Social Security, but will also have the right to examine all of a physician's records both in the hospital and office in order to make appropriate comparisons as to treatment and charges rendered to private patients. The physical facilities in the office also can be inspected.

(9) All physicians who receive payment for treatment of Medicare-Medicaid patients are subject to the provisions of the PSRO law.

(10) In elective cases or in cases where an unusual expense is expected, pre-admission authorization from PSRO committee can be required before a patient could be hospitalized.

(11) Where there is an effectively functioning utilization and quality care committee within a hospital, this committee can be accepted as the PSRO agent for that hospital.

(12) A PSRO is initially accepted on a one or two year basis. At that time its activities are reviewed to determine whether or not the HEW secretary judges it effective enough to be redesignated for another term.

(13) If no physician organization applies as a PSRO for an area by 1976, the HEW secretary must choose some other qualified group to fulfill this function. It seems likely that in order of choice the following will be considered: a state health department; a medical school; an insurance carrier such as Blue Cross-Blue Shield.

(14) Physicians will be encouraged to participate in the review committee activities on a rotating basis. It is estimated that while he is serving on the committee, a physician will have to devote one full day a week or about 15 per cent of his time to review activities. Physicians will be paid for their time spent in review.

(15) Non-M.D., non-osteopathic providers such as chiropractors and physical therapists will also be subject to review. There will be no non-physician providers represented on review committees, but they will be asked to serve as paid consultants.

(16) No guidelines have yet been released except those regarding area designation. Complete guidelines might not be available until January, 1976.

(17) At present, HEW indicates that about 185 PSRO areas will be established and about 50 PSR organizations will be approved by July 1, 1974.

IV. Action by AMA and others on PSRO

At this point, it is worth noting the course the AMA has taken since this law was passed approximately 14 months ago. Two months after passage of the law, in December 1972 at the Clinical session in Cincinnati, the AMA passed Report Z, sponsored by the Board of Trustees. It called for the AMA to take a "leadership role in the implementation of PSRO." As a national follow-up to this, an AMA PSRO Study Committee was appointed, chaired by AMA Trustee, Dr. Robert Hunter, an advocate of cooperation with the law.

In June, 1973, at the Annual Session in New York, a resolution was passed calling for the AMA to continue to study PSRO, but to point out the "deleterious facets" of the law. No action has been taken on this and the AMA has been criticized for its failure in this area.

At the recent Clinical Session in December 1973 at Anaheim, California, the AMA Board of Trustees frequently referred to its instructions of a year ago to provide leadership toward constructive implementation and to support efforts toward formulation of appropriate rules and regulations. Those delegates working for repeal were critical of the Board of Trustees for apparently avoiding discussion of undesirable aspects of PSRO.

The Council on Legislation in Report EE of the Board of Trustees gave an interim account of its studies to identify sections of the law which should be eliminated or amended. It pointed out some 20 such changes initially to be recommended to Congress and worked for by the AMA.

The Reference Committee, after extensive hearings concluded:

(1) Attempts at absolute repeal of the law would be fruitless.

(2) Should such an effort be made it would weaken attempts by the AMA to achieve needed amendments to the law.

(3) This posture would also weaken the position of the AMA in its work on future health legislation.

(4) Repeal of PSRO would leave the profession subject to more damaging controls, some of which are already possible under existing statutes.

(5) The AMA should not rule out the possibility that at a later date, repeal might become a more "viable and appropriate" action. The House of Delegates, in a move to work for repeal, passed an addendum to the Board of Trustees report which is included in our Committee's recommendations. (The full Board of Trustees Report as amended has been distributed to you.)

Several resolutions were introduced asking for the AMA to rescind its actions of a year ago, in which the Board of Trustees was instructed to exert a leadership role toward implementation of the law, but the House of Delegates, although there was considerable sentiment for repeal, did not want to stop the work of Dr. Hunter's study committee, which seemed to be investigating the facts and implications of the law and simultaneously developing a mechanism for its implementation. This issue will come before the House of Delegates in June 1974.

Some of the other activities occurring around the country regarding PSRO include:

(1) Several bills introduced in Congress, perhaps as many as six or eight different bills, to repeal the PSRO law. Forty Congressmen have committed themselves to vote and work for repeal.

(2) Ten state medical societies have decided to work for repeal of the law although some of these are also preparing for implementation if the repeal effort fails. The Tennessee legislature has passed a resolution asking Congress to repeal the law.

(3) A suit filed by the American Association of Physicians and Surgeons in Federal Court in Chicago to have the law declared unconstitutional. This suit is now under study.

V. Apprehensions relative to the effect of the PSRO Law

Members of your PSRO Committee as well as physicians around the state have expressed extreme apprehension regarding implementation of the PSRO law. These fears may be categorized as follows:

(1) Cost—at present ultimate costs are unknown. The amount stated by HEW is that each PSRO will cost about $300,000.00 the first year for start up costs. Other estimates are that the entire PSRO activity will require an expenditure of $500 million within a year. This is considerably more than the review activities can be expected to save. These costs will have to be met through increased Social Security taxes.

(2) Utilization—probably will be increased. Under the threat of malpractice suits, increased hospital admissions, testing and laboratory studies have been substituted for clinical judgement; and under the norms and standards a similar thing likely will occur. The review process possibly will uncover much under-utilization, reports of some foundations suggest.

(3) Health care cost—probably will increase, rather than decrease. Since the primary purpose of the law is to curtail costs, those working under it might be blamed for its failure to accomplish this objective.

(4) Confidentiality in doctor-patient relationship—this will be eliminated. All information from a patient's chart will be available to PSRO committees including groups of doctors and laymen. Physician office records

can also be investigated, both for Medicare and Medicaid patients and for private patients.

(5) Malpractice claims—these unquestionably will increase. At a recent national meeting of plaintiff attorneys, the word was passed that PSRO standards can be used to establish deviation from good medical practice by a physician and will thus indicate liability on his part. The HEW Secretary has not yet indicated whether or not PSRO records will be available in civil suits, a prerogative he is allowed under the law. When a case is rejected by the PSRO, the patient will be told that his care did not measure up to prescribed standards and public disclosure can also be made.

(6) Liability of the physician reviewer—at present, it seems that the record of PSRO activities may be immune to subpoena by the courts and it is possible that those on review committees will be protected. This has not yet been decided by the Secretary of HEW.

(7) Ultimate outcome as regards non-Medicare-Medicaid patients—it is envisioned that each hospital will be connected by a computer terminal to a national data bank. The Bureau of Health Standards will then insist that all patients, not just Medicare-Medicaid patients, conform to the PSRO norms and standards. Thus all patients covered by insurance will come under provisions of the PSRO law.

(8) Effect on practitioner—the requirement to practice by detailed norms and standards will be markedly restrictive on the physician and will limit the value of utilizing experience and clinical judgment in planning diagnostic procedures and treatment of the patient. There will be increased paper work. PSRO's will harass physicians with hearings, fines and public disclosure of violations.

(9) It appears now that a physician whose practice conforms to PSRO regulations will be held blameless if his treatment produces unexpected or bad results. This promotes "cookbook medical care" with resulting deterioration in the quality of care and dehumanization of care.

(10) The quantity of care may be decreased due to rationing of money when appropriated funds run low.

(11) Innovative medical care may be discouraged because new procedures or treatments would not be covered under the norms.

(12) Physician time badly needed for patient care will be spent in administrative function for the organization.

(13) The magnitude of the problems to be encountered will discourage young people from going into practice especially at the community level.

(14) Some physicians could refuse Social Security patients.

(15) PSRO will be a totally new massive and expensive bureaucracy estimated by some to cost five times the amount saved in dollars with no estimate of the cost in physician time.

The declared purpose of this law is to "promote effective, efficient and economical delivery of health care service of proper quality." We recognize the problems existing in medical practice. Our hospital utilization committees, county and state medical society peer review committees, the Foundation, all are attempts of physicians to deal with these problems, but our review processes, although extensive, have not been pursued vigorously enough to overcome the abuses, over-utilization and the substandard practices of a small minority among us. Thus we will continue to make every effort to improve these procedures to insure that our patients are receiving quality medical care at reasonable cost. This can best be accomplished, we are convinced, within the context of the private practice of medicine and its organizations.

VI. Subcommittee Reports

Within the PSRO committee, subcommittees have been set up to provide more detailed study of various aspects of the PSRO law. I would like to call upon the members of the committee to give their reports as well as make any personal comments, at this time.

First, Models and prototypes: L. C. Buchanan, M.D., F. William Dowda, M.D. and B. W. Forester, M.D.

Second, Structure and Organization: L. T. Crimmins, M.D., Thomas G. Douglass, M.D. and Charles D. Hollis, M.D.

Third, Data Collection, Processing, Storage and Computers: Joseph M. Almand, Jr., M.D.

Fourth, Program Evaluation: James A. Kaufmann, M.D. and James J. Oosterhoudt.

Fifth, Communication and Education: Louis Felder, M.D. and R. D. Walter, M.D.

Sixth, Costs: Charles W. McDowell, Jr., M.D. and John P. Heard, M.D.

Seventh, Alternatives: W. Dan Jordan, M.D. and J. K. Quattlebaum, M.D.

Report of the Sub-Committee on Data Collection, Processing, Storage and Computers

We have been diligently studying all facets of data collection, data processing, computer leasing and profiles, as well as data storage.

The minutes and thoughts of a prior sub-committee meeting at MAG Headquarters are available on request of the MAG office.

Caution and investigation of each problem, one at a time, should be the watchwords of this sub-committee.

Minutes of the AMA Task Force on Data Collection, Processing, and Storage have been read and studied and each meeting's minutes are forwarded to our subcommittee.

Problems existing and possible solutions are as follows:

A. Identification of minimum data set for Professional Standards Review

1. Uniform Hospital Discharge Data Set (Hereafter referred as UHDDS)

COMMENT: We feel and recommend that EMCRO, JCAH, CHIP, SNAP, PAS, HASP, etc. all data collectors, i.e. get together and agree on a single UHDDS. This should be on a national level supervised by AMA.

2. Guidelines work sheet and sample guidelines of Care

COMMENT: Should be solved the same way as in number one above.

3. Physician identification number

COMMENT: The Social Security should suffice for physician ID number—even if in partnership, corporation, group, medical school, private practice; every physician has a social security number.

4. Patient identification number:

COMMENT: a) Social Security Number would not suffice; too many people use same social security number; and, also, many do not have a number; b) Proposal that might require up to 40 characters on a computer.

1. Whole Name—25 or less characters;
2. Sex—1 character (male or female);
3. Race—1 character (white, black, other);
4. State of birth (4 characters) Use national post office abbreviations;
5. Date of birth (8 characters) 12/12/73, 12/12/1898 (75 years).

Total Characters: 39

5. Uniform Medical Terminology

COMMENT: Blue Shield, SNOP and SNOMED, etc., have been suggested. Why not use ICDA, which is world wide and means International Classification of Diseases (Adapted Eighth Revision).

6. Uniform procedural terminology (Same as Number 5 above)

COMMENT: Use ICDA

7. Data Collection Mechanisms

COMMENT: Get together a group on a National Level from: Title XIX—Medicaid; Title XVIII—Medicare, Blue Shield, all private insurance companies, group insurance plans, etc. and let this committee agree and choose one data collection document.

8. Procedures for access and use of PSRO data in accordance with (a) quality care; (b) confidentiality; (c) privacy, and (d) educational requirements.

COMMENT: If this cannot be met with surety, PSRO should not be allowed to exist.

9. Computer and storage capacity: future reports will deal with this highly complex area.

The committee feels we should proceed with caution, and if PSRO is implemented, attempt to solve one problem at a time. These minutes will be exchanged with the National AMA PSRO Task Force as well as their minutes be transcribed and studied by our MAG Task Force Committee.

James H. Sullivan, M.D.
Joseph M. Almand, Jr., M.D.

Report of the Subcommittee on Alternatives

Consideration will be given to alternatives *to* the law and alternatives *within* the law.

A. Alternatives *to the law* include:

1. Repeal of the law—It appears that an overwhelming majority of congressmen voting for the PSRO section of PL 92-603 had not read the bill, and as they have become aware of its contents may be expressing second thoughts. It is reported that a considerable number of representatives have agreed to support legislation to repeal the law at this time. Several state medical societies (Maine, Virginia, Michigan, Indiana, Kentucky, Louisiana, Texas, Oklahoma, Nebraska and Nevada) and multiple large county societies across the country have expressed opposition to the law and are working for its repeal.
2. Declaration of the law to be unconstitutional—The Association of American Physicians and Surgeons filed suit in June, 1973, with a federal district court in Illinois testing the constitutionality of the PSRO section of the law. Restraining injunctions have been prepared in the event a decision has not been made by January 1, 1974, when the law is to be implemented.
3. Refusal to treat Medicare and Medicaid patients—If repeal or court rejection is not forthcoming the only other alternative that the individual physician has to avoid coming under the jurisdiction of this law is to not treat any patient whose bill may either wholly or in part be paid by Social Security.



Bruce C. Newson, Columbus delegate, has the floor while O. Wytch Stubbs, Jr. of Chamblee and Irving L. Greenberg of Atlanta await their turns to clarify, propose and amend items before the House.

B. Alternatives *within the law* would include:

1. Alternatives for the individual physician.

a. Whether or not to participate in review activities—Under the law review activities in each hospital will be carried out either by the hospital audit committees or, in the absence of effective function, by the local PSRO itself. The local PSRO must encourage the physicians to become members and participate in the review functioning, but membership is voluntary. For the first two years, the PSRO must be a physician's organization after which it can be a health department, medical school, or an insurance carrier (to be determined by HEW). If the individual physician elects to perform review for the PSRO, he may not be responsible for (but may participate in) review in his own hospital, and will probably be called upon to review activities in a hospital in which he is not active. If the hospital audit committee is approved by the PSRO, then the physician's duties will depend upon the hospital staff bylaws and requirements. In either event, the physician reviewing would be acting as an agent of the government. Parameters of care reviewed may be created at the local level but must ultimately be approved by the regional and national PSRO agencies.

b. Whether or not to accept a physician's organization which offers itself as a PSRO during the first two years—If such a physician's group applies for a PSRO agency within a given area, the practicing physicians must be notified prior to approval by the Secretary of HEW. If, within a reasonable period of time, 10 per cent of the physicians practicing in an area challenge that

organization as not being representative, then a referendum must be held, and if more than 50 per cent of the physicians voting reject this organization, then the Secretary is by law not allowed to appoint such an agency. This provision is applicable only until 1 January, 1976.

2. Alternatives for the profession as a whole, i.e., MAG, include:

a. Whether or not to participate in the formation and operation of PSRO—Participation by MAG would mean involvement of the administrative staff, both physicians and nonphysicians, in the framework of the organization responsible for the review of medical care delivered under the Social Security Act. It would also mean that this parent organization in which MAG would be active would be the more immediate appeal agency regarding parameters of care and sanctions. The expertise available to MAG from its foundation and EMCRO activities would be well utilized. Organizational expenses of the PSRO would be funded by the federal government. If, on the other hand, MAG refuses to participate and actively opposes participation, it is likely that there would be no PSRO functioning within the state until after January 1, 1976, when health departments, medical schools, or insurance carriers could be appointed as PSROs without concurrence of the profession. In that event, it is likely there would be a rather massive extension of the activities currently going on within the state under the auspices of the intermediaries already involved. If the physicians are not active in implementing the PSRO activities, there would likely be a great deal of confusion involving the patients and hospital activities as well as greatly increased expense.

A decision as to whether or not to sponsor a PSRO does not have to be made at the present time, for the Secretary of HEW may not contract with other than a physician organization prior to 1976. Should MAG as an organization elect to proceed with implementation, apply, and be designated as a PSRO, it could, according to its ability, begin by reviewing only a portion of the coverage and then in a step-wise fashion gradually increase to total review over a two year period as its capabilities improved.

b. Whether or not to assist directly or in an educational way the various hospital review programs scattered over the state so that eventually with a PSRO designation to some agency a satisfactory relationship could be accomplished. Under the law a PSRO may accept an in-hospital review program but only for so long as it accomplishes those things the PSRO is charged with reviewing and does so in a timely fashion. The advantages of this local review are that variations from the standards are judged locally and initial sanctions are applied locally. There is also no retrospective denial of claims again assuming that the hospital utilization review activities are accepted by the local PSRO. The expertise the MAG has from its foundation and EMCRO programs could be extremely helpful to the hospital utilization review committees as they proceed with this degree of implementation.

VII. Options for MAG

Before formulating any recommendations, let us consider the four options that MAG seems to have, as already, to a degree presented by the subcommittee on alternatives.

(1) Ignore the law. In this case, in January 1976, the HEW Secretary will designate an organization, probably the Department of Human Resources, to administer the PSRO functions. The norms and standards will be established by the state agency with the approval of HEW. Public health physicians or other physicians who volunteer such as cooperative practitioners and medical school professors, will serve on review committees. Our relationship with the organization will likely be similar to the physician's relationship to the Prudential Insurance Company in the administration of Medicare, Part B. There will be no input into the establishment of norms, no participation in the review procedures, and little recourse when a decision is made which the doctor believes is contrary to the best interests of the patient or physician. However, the attending physician could refer questions and problems to the government agency and direct criticism to it. He would spend less time in committee activities.

(2) Work to repeal the law and devote the full resources of MAG to this effort. Formulate no contingency plan. Accept no compromise. In this case, if successful, the PSRO problem would be eliminated. If the effort fails, the outcome would be the same as under (1) above.

(3) Work to repeal, but continue to formulate some contingency procedure. In this instance, the MAG would devote its full energies to repeal of the law. It would direct an intensive public and professional educational campaign to warn of the undesirable aspects of PSRO. Concomitantly, it would continue to study the process of implementation in areas where this has begun. It would also make available some skeleton organization which could be immediately activated should MAG decide that the best interests of physicians and society could be served by maintaining physician control, insofar as possible, of the review process. It would make concerted and continuing efforts through the political process to modify and improve the law should efforts at repeal fail.

(4) Work to implement the legislation immediately, feeling that by energetic physician input at this time, the physician would have more ultimate influence on the final product.

VIII. Committee Conclusions and Recommendations

What is the current thinking within the committee as to the proper course of action by MAG at this time?

Much is yet unknown. Guidelines have not been released. However the committee offers the following conclusions and recommendations:

(1) Work for repeal of the law.

(a) It is the opinion of this committee that many aspects of this law are ill-conceived and will prove detrimental to the patient and to the physician, and the government. If national health insurance is subsequently enacted PSRO will quite likely be the framework upon which the controls for this mammoth program will be built.

Parenthetically, this raises unsettling questions. (1) If we in medicine cannot assemble sufficient political

influence to prevent passage of a costly national health bill, not yet on the books, how realistic is it to hope for repeal of an existing cost control bill already in effect? (2) If PSRO is the forerunner of more extreme control measures under national health insurance, how urgent is it for physicians to make the attempt now to keep the mechanism in the hands of practitioners? (3) If PSRO should be repealed, what methods of accountability are we prepared to offer the public for the expenditure of billions of dollars of federal money in which we participate?

This committee feels, however, that the PSRO law as designed, cannot accomplish the avowed purposes of cost control and improvement of quality of care. The profession should not voluntarily commit itself blindly to a program which seems doomed to failure, accepting the criticism and blame for that failure for which it is not responsible.

Our officers, councilors, and Executive Committee should be instructed to work for repeal and inform the AMA and all other state medical associations of our decision.

(b) In addition, we should:

(1) Urge the membership to work in a united way toward this end.

(2) Notify our representatives in Congress of our position and request their help.

(3) Ask the AMA for financial support and ask AMA to work with the Congress.

(4) Communicate with those in health related organizations and ask for support.

(5) Encourage the membership to inform its patients about the disadvantages of the law and mount a letter campaign to Congress asking for repeal of the law.

(2) Take no action at this time to implement the law. Under the law organized medicine has two years to make this decision. The physicians of Georgia are particularly reluctant to attempt to perform the function of a PSRO except under the aegis of a statewide umbrella organization. The HEW has not yet announced whether or not it will designate Georgia as a statewide area. The matter should be reconsidered by the MAG House of Delegates at its Annual Session in May, 1974.

(3) Launch an educational campaign directed toward the MAG membership, informing them of the progress being made by HEW toward implementing the PSRO law. If the MAG chooses not to assist in this program, advise the physicians of Georgia of the possibility of some unrepresentative group of physicians applying for recognition as a PSRO. Offer assistance to the physicians of an area to assure that any PSRO established has broad representation.

(4) Continue to study the full implications of the law. Observe closely the progress in development of HEW guidelines for PSRO. Maintain communication with those in HEW responsible for PSRO activities. Remember that the law was made in Congress and handed to HEW for implementation. Offer advice and counsel to those working on PSRO when this is requested.

(5) Develop an alternate plan, should efforts at repeal fail. Instruct the subcommittees of the PSRO Study Committee to continue to accumulate data necessary to construct a functioning PSRO system within the state. Identify the sections of the law most deleterious to good medical practice and most contrary to the public interest. Make a vigorous effort in cooperation with AMA to have these sections of the law eliminated or substantially modified. Offer the suggestion that instead of norms and standards, national criteria be concerned with only admission and length of stay parameters, leaving medical audit to state and local medical review committees.

(6) Institute massive legislative and public educational programs.

(a) Reaffirm MAG's commitment to the principles of peer review and formal accountability in the expenditure of public funds.

(b) State that present review procedures, although not perfect, are more comprehensive than those functioning within any other organized professional group. Point out that the profession is studying ways of improving the existing methods.

(c) Indicate that quality of care as rendered by the profession is high and that physicians are more responsive and sensitive to public needs than members of other professions and organized groups.

(d) Emphasize that although the present medical care system does not always meet all the *demands* of the public, that in all but rare exceptions it is meeting the *needs* for necessary medical services. Note that these services are provided at a lower unit cost than can be offered under a government controlled system.

(e) Admit that it is appropriate for government and the public to encourage and stimulate efforts at improvement and efficiency in the medical delivery system. Insist, however, that more can be accomplished by innovations in a basically sound system than by establishing an entirely new and massive bureaucracy which is certain, by past experience, to be costly, inefficient and poorly responsive to the public needs.

(f) Keep Georgia's representatives in Congress informed on a continuing basis about MAG's opinions and actions on matters related to PSRO.

(7) Support studies in various methods of review processes to discover more effective and expeditious ways to provide controls on an independent basis.

(8) Encourage all hospital medical staffs to evaluate their review committee functions to be sure that they are performing medical audit as well as utilization control. This will improve the present peer review process and will also be available for PSRO functions should this become necessary or desirable.

(9) Maintain liaison with other state medical associations so as to approach problems related to PSRO on a cooperative basis.

(10) Approve the following position statement of AMA, developed by the AMA House of Delegates:

"The AMA affirms the following principles:

1. That the medical profession remains firmly committed to the principle of peer review, under professional direction, and
2. That medical society programs of proven effectiveness should not be dismantled by PSRO implementation, and
3. That the Association suggests that each hospital medical staff, working with the local medical society, continue to develop its own peer review, based upon principles of sound medical practice and documentable objective criteria, so as to certify that objective review of quality and utilization does take place; to make these review pro-

cedures sufficiently strong as to be unassailable by any outside party or parties; and that the local and state medical societies take all legal steps to resist the intrusion of any third party into the practice of medicine, and

4. That this House of Delegates, as individual physicians and through the Board of Trustees and its Council on Legislation, work to inform the public and legislators as to the potential deleterious effects of this law on the quality, confidentiality and cost of medical care; and the hope that the Congress in its wisdom will respond by either repeal, modification, or interpretation of rules which will protect the public.

The considered opinion of this House of Delegates is that the best interests of the American people, our patients, would be served by the repeal of the present PSRO legislation. It is also believed that this is consistent with our longstanding policy and opposition to this legislation prior to passage."

Thank you, Mr. Speaker. This concludes the report of the Committee on PSRO.

Delegate Edwin C. Evans, M.D., for the Medical Association of Atlanta, then offered the following amendment to the Committee Report.

Approve the report of the PSRO Committee with the following changes: delete lines 4 through 39 on page 17, and lines 1 through 13 and 28 through 38 on page 18; and

1. MAG should vigorously seek repeal of the law
   A. If HEW persists in not granting statewide PSRO designation
   B. Unless guidelines are issued which indicate that the law will be implemented in a way constructive for physician and patient
   C. Unless HEW agrees to support legislative changes to eliminate objectionable punitive elements of the law—such as those identified by the AMA Council on legislation
2. Take no action to implement at the present time because HEW has disregarded the well meaning efforts of MAG to develop a system under statewide designation whereby physicians in Georgia could satisfactorily implement the PSRO law.
3. Although HEW in ignoring our good faith effort has raised serious doubt as to its willingness to work with the doctors in Georgia as partners, MAG will reconsider this position if statewide PSRO designation is granted to Georgia and the department of HEW works with MAG to develop a proposal to present to the House of Delegates in May 1974.

Recession

Speaker Rogers then announced that the first session of the Special Session of the MAG House of Delegates would stand recessed at 5:20 p.m., and that the second session would reconvene on Sunday morning, December 16, 1973, at 8:30 a.m.

Highlights of MAG Executive Committee of Council

December 15, 1973

Appointments: Communications Committee—Marvin Cohen, M.D., Columbus; J. Kenneth McDonald, M.D., Augusta. Committee on Maternal and Infant Welfare—Jules Terry, M.D., Atlanta, State Dept. of Human Resources.

Georgia Medical Care Foundation: Deferred consideration of Foundation Bylaw changes to February. Received report on submission of CHEC (concurrent hospital review) proposal to state for inclusion in F.Y. 75 budget.

Quality Assurance Proposal: Approved submission of grant proposal to GRMP for quality assurance in smaller hospitals with small medical staffs.

Savannah HMO: Received for information report on Westside Comprehensive Health Center, originally planned as clinic for poor, now proposed as HMO.

Cancer Management Network: Accepted responsibility for Cancer Network with fiscal matters to be administered through GRMP.

Commendation of James B. Craig, M.D.: Voted unanimous resolution of respect and confidence in professional integrity and competence of Dr. Craig.

Next Meeting: 9:00 a.m. Saturday, January 12, 1974, Atlanta Internationale Hotel.

Second Session—House of Delegates

Sunday, December 16, 1973

THE SECOND SESSION of the Special Session of the House of Delegates of the Medical Association of Georgia was called to order by Speaker Harrison L. Rogers, Jr., M.D., of Atlanta at 8:30 a.m. in the North Ballroom, Marriott Motor Hotel, Atlanta, Georgia.

Speaker Rogers called for a report of the delegates in attendance. S. William Clark, M.D., Waycross, chairman of the Credentials Committee, reported that there were 72 registered delegates present for the second session and, accordingly, a quorum was present. (A final tally of the Credentials Committee indicated at the second session 128 Delegates representing 37 medical societies.)

Attendance

BIBB: Charles Duggan, Warren L. Griffin, Jr., F. V. Kay, C. G. Magnan, Jack Menendez, S. Charlotte Neuberg, B. B. Sanders; OGEECHEE RIVER: Leon E. Curry; CARROLL-DOUGLAS-HARALSON: J. Larry Boss, Clark Robinson; GEORGIA MEDICAL SOCIETY: Burton D. Goodwin, Frank M. Johnston, J. Robert Logan, F. Debele Maner, J. V. Morrison, Joseph A. Mulherin, Dearing H. Nash, William G. Sutlive; CHEROKEE-PICKENS: C. J. Roper; CRAWFORD W. LONG: Donald L. Branyon; CLAYTON-FAYETTE: Wells Riley; COBB: F. Norman Bowles, Remer Y. Clark, Steve May, Virgil L. Curran, Gary Palmer, Donald R. Rooney, Charles Underwood; CHATTAHOOCHEE: Rupert H. Bramblett; COLQUITT: John Pierce Tucker; DEKALB: Duane Blair, Timothy Harden, Jr., John P. Heard, Kenneth Hoose, Jr., Charles McDowell, LaMar McGinnis, Frank E. Morgan, Jr., Benjamin Okel, William J. Rawls, Roger R. Rowell, Roy Vandiver; DOUGHERTY: J. Dan Bateman, D. M. Boyette, Charles D. Hollis, Robert D. Waller; FLINT: J. T. Christmas; FLOYD-POLK-CHATTOOGA: James A. Routledge, Jack M. Waldrep; MEDICAL ASSOCIATION OF ATLANTA: T. J. Anderson, Jr., John S. Atwater, J. T. Blasingame, James N. Brawner, Spencer S. Brewer, Jr., F. William Dowda, Edwin C. Evans, Louis Felder, Joseph L. Girardeau, Irving L. Greenberg, Charles E. Harrison, J. Harold Harrison, J. Rhodes Haverty, Armand E. Hendee, L. W. Hobby, William E. Huger, Jr., J. R. B. Hutchinson, Fleming L. Jolley, W. Dan Jordan, James A. Kaufmann, William D. Logan, John T. McCain, John M. McCoy, Keith Quarterman, Harold S. Ramos, A. A. Rayle, Harrison L. Rogers, John K. Schellack, Parry Soder, Ignatius Stein, Thomas L. Tidmore, Jr., Charles E. Todd, Robert E. Wells, Frank L. Wilson, Joseph S. Wilson, D. C. Whitney; GLYNN: M. A. Glucksman, Edwin A. Mayo, William J. Smith; GORDON: R. D. Walter; HABERSHAM: Thomas N. Lumsden; HALL: Larry N. Durisch, Donald R. Luke, Harvey Newman; JACKSON-BANKS: E. W. Holloway; LAURENS: O. B. Johnson, Robert Oliver; MCDUFFIE: Thomas E. Averitt; MUSCOGEE: J. H. Deaton, J. A. Raines, B. R. Maughon, Bruce C. Newsom, R. E. Thompson; RICHMOND: Joseph P. Bailey, Jr., James L. Becton, Claude Boyd, Curtis Carter, Thomas B. Douglass, Ronald F. Galloway, William E. Lotterhos, J. Kenneth McDonald, Stuart H. Prather, Jr., Luther J. Thomas, Jr.; SOUTH GEORGIA: Frank Eldridge, Joe C. Stubbs; SPALDING: James Skinner; STEPHENS: Peter C. Lampros; THOMAS AREA: Frank R. Miller; TIFT: W. O. Holloway; TROUP: Joseph M. Almand, H. Hilt Hammett; WALKER-CATOOSA-DADE: Ted D. Cash, M. K. Cureton; UPSON: T. A. Sappington; WARE: F. E. Davis, S. W. Clark; WASHINGTON: William Rawlings; WHITFIELD: James Oosterhoudt, Jr.; WILKES: M. G. Adair; WORTH: H. G. Davis.

The Speaker reminded the House that the facilities of the hotel would not be available to the House of Delegates after 12:45 p.m. and therefore urged that the Assembly address itself to the business at hand with dispatch.

The Speaker announced that the House would continue its order of business beginning where it had left off the previous day and accordingly asked the members of the Committee on PSRO to be seated at the front of the room and then proceeded to introduce the members of the Committee as follows: Charles D. Hollis, Albany, chairman; L. T. Crimmins, Albany; F. William Dowda, Atlanta; John P. Heard, Decatur, vice-chairman; James J. Oosterhoudt, Dalton; Robert L. McDowell, Decatur; R. D. Walter, Calhoun; L. C. Buchanan, Decatur; J. K. Quattlebaum, Savannah; James H. Sullivan, Columbus; Thomas G. Douglass, Augusta; Beverly W. Forester, Macon; Joseph M. Almand, Jr., LaGrange; James A. Kaufmann, Atlanta; W. Dan Jordan, Atlanta; Louis Felder, Atlanta; Harvey J. Schechter, D.O., Tucker, ex-officio.

Speaker Rogers opened the floor for discussion of PSRO. The Chair recognized PSRO Committee

Chairman, Dr. Charles Hollis, who moved the adoption of the report of the Committee on PSRO.

Delegate Edwin C. Evans, Atlanta, moved to amend the PSRO committee report by use of the language offered as the MAA amendment the previous day. Attempts to amend the MAA amendment failed and a vote to terminate debate subsequently was adopted. A vote was then taken on the MAA amendment to the PSRO committee report and that amendment lost.

Subsequently, the House voted to adopt the PSRO committee report without amendments.

The Speaker then recognized delegate Louis Felder, M.D., Atlanta, who moved the immediate adjournment of the House. Delegate J. Rhodes Haverty of Atlanta asked for a point of clarification concerning the intent of the House in adopting the report of the Committee. The question was asked of PSRO Committee Chairman, Dr. Hollis, if his committee report precluded an effort by Executive Committee of Council to work toward single PSRO area designation for Georgia and Dr. Hollis responded that he did not think so. There was no disagreement with this view evident in the House. The House then voted 62 to 47 to adjourn. Accordingly, the Speaker declared the 1973 Special Session of the MAG House of Delegates adjourned at 12:45 p.m.

Organ Transplant Registry Shows Much Is Still Experimental

Although kidney transplants are now an effective treatment for certain patients, other human organ transplantation must still be considered as experimental, according to the most recent report from the American College of Surgeons/National Institutes of Health Transplant Registry.

The report is based on follow-up information on 12,389 kidney transplants and over 500 grafts of other organs. Results indicate that long-term kidney transplant function is the rule in most cases, and long-term survival of the recipient is to be expected. Moreover, survival with graft function has usually meant normal living, including 62 instances in which the recipient has become pregnant.

The report, which is the eleventh of the Human Renal Transplant Registry, was carried in the December 3, 1973 issue of the *Journal of the American Medical Association.*

The Third Scientific Report of the Organ Transplant Registry, also carried in that issue, notes that all other types of transplantation—heart, liver, lung and pancreas—have less encouraging results and must be viewed as still experimental.

Although mild encouragement is derived from the fact that an occasional patient is indeed benefited by a heart, liver or lung transplant, the report states, accurate prediction of which patient will have a good result has not been achieved.

Through 1972 for instance, a total of 202 cardiac transplants were performed, 132 of them in the United States; but as of January 1, 1973, there were only 26 survivors—22 of them in the United States. During 1972, there were 17 transplantations performed in this country, 13 of them at Stanford University. There were 7 survivors, all at Stanford. Graft rejection, infections, malignant neoplasms and graft atherosclerosis continue to take a high toll, the report states, but 29 patients have survived two or more years, six of them for four years or more.

As of January 1, 1973, a total of 182 liver transplants had been performed on 178 patients. Early survival after liver transplantation has been accomplished fairly regularly, but few patients have achieved extended survival.

Maintenance of the registries and the analysis of the data they contain are the responsibility of the American College of Surgeons under a contract with the National Institutes of Health.

Georgia Medical Care Foundation Locates in New Offices

The Georgia Medical Care Foundation moved into larger accommodations on January 2, 1974. The new office is located in Suite 450, 1100 Spring Street, N.W., Atlanta, Georgia, and the new business phone is (404) 875-7254. There is convenient parking nearby and an open invitation is extended to all physicians interested in learning more about Foundation activities.

The Bradley Center

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The Center offers a broad spectrum of clinical services including inpatient, day treatment and outpatient programs. Individuals, couples and families are provided an opportunity for multiple psychotherapeutic encounters. A dynamically oriented staff representing all the major mental health disciplines allows the flexibility necessary to design a treatment approach consistent with the unique need of each individual.

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Medical Director

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The irritations of man's day are often reflected in his gut.

The causes of irritable colon and the diarrheal symptoms that often accompany it can be as diverse as the systemic and emotional irritations man is faced with daily.

Although the mucoid nature of stools and the occurrence of diarrheal episodes coincident with times of emotional stress may be valuable clues to the functional nature of the disorder, irritable colon must often be diagnosed by exclusion. Such diagnostic exploration takes time. Discovery of the nature of any emotional problems may take more. During that time, Lomotil® is an ideal agent for controlling diarrheal symptoms.

Lomotil tablets are small, easy to carry and easy to take. They act promptly and effectively. Secondary effects are relatively infrequent and, once the first force of the diarrhea is controlled, maintenance is frequently effective on as little as one fourth of the initial dosage.

These same characteristics make Lomotil useful in controlling the diarrhea associated with gastroenteritis, antibiotic therapy and acute infections.



Lomotil®

TABLETS/LIQUID

Each tablet and each 5 ml. of liquid contain:
diphenoxylate hydrochloride . . . 2.5 mg.
(Warning: May be habit forming)
atropine sulfate . . . . . 0.025 mg.

takes care of the gut issue in irritable colon

IMPORTANT INFORMATION: *This is a Schedule V substance by Federal law; diphenoxylate HCl is chemically related to meperidine. In case of overdosage or individual hypersensitivity, reactions similar to those after meperidine or morphine overdosage may occur; treatment is similar to that for meperidine or morphine intoxication (prolonged and careful monitoring). Respiratory depression may recur in spite of an initial response to Nalline® (nalorphine HCl) or may be evidenced as late as 30 hours after ingestion. LOMOTIL IS NOT AN INNOCUOUS DRUG AND DOSAGE RECOMMENDATIONS SHOULD BE STRICTLY ADHERED TO, ESPECIALLY IN CHILDREN. THIS MEDICATION SHOULD BE KEPT OUT OF REACH OF CHILDREN.*

Indications: Lomotil is effective as adjunctive therapy in the management of diarrhea.

Contraindications: In children less than 2 years, due to the decreased safety margin in younger age groups, and in patients who are jaundiced or hypersensitive to diphenoxylate HCl or atropine.

Warnings: Use with caution in young children, because of variable response, and with extreme caution in patients with cirrhosis and other advanced hepatic disease or abnormal liver function tests, because of possible hepatic coma. Diphenoxylate HCl may potentiate the action of barbiturates, tranquilizers and alcohol. In theory, the concurrent use with monoamine oxidase inhibitors could precipitate hypertensive crisis.

Usage in pregnancy: Weigh the potential benefits against possible risks before using during pregnancy, lactation or in women of childbearing age. Diphenoxylate HCl and atropine are secreted in the breast milk of nursing mothers.

Precautions: Addiction (dependency) to diphenoxylate HCl is theoretically possible at high dosage. Do not exceed recommended dosages. Administer with caution to patients receiving addicting drugs or known to be addiction prone or having a history of drug abuse. The subtherapeutic amount of atropine is added to discourage deliberate overdosage; strictly observe contraindications, warnings and precautions for atropine; use with caution in children since signs of atropinism may occur even with the recommended dosage.

Adverse reactions: Atropine effects include dryness of skin and mucous membranes, flushing and urinary retention. Other side effects with Lomotil include nausea, sedation, vomiting, swelling of the gums, abdominal discomfort, respiratory depression, numbness of the extremities, headache, dizziness, depression, malaise, drowsiness, coma, lethargy, anorexia, restlessness, euphoria, pruritus, angioneurotic edema, giant urticaria and paralytic ileus.

Dosage and administration: ***Lomotil is contraindicated in children less than 2 years old.*** Use only Lomotil liquid for children 2 to 12 years old. For ages 2 to 5 years, 4 ml. (2 mg.) t.i.d.; 5 to 8 years, 4 ml. (2 mg.) q.i.d.; 8 to 12 years, 4 ml. (2 mg.) 5 times daily; adults, two tablets (5 mg.) t.i.d. to two tablets (5 mg.) q.i.d. or two regular teaspoonfuls (10 ml., 5 mg.) q.i.d. Maintenance dosage may be as low as one fourth of the initial dosage. Make downward dosage adjustment as soon as initial symptoms are controlled.

Overdosage: Keep the medication out of the reach of children since accidental overdosage may cause severe, even fatal, respiratory depression. Signs of overdosage include flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia and respiratory depression which may occur 12 to 30 hours after overdose. Evacuate stomach by lavage, establish a patent airway and, when necessary, assist respiration mechanically. Use a narcotic antagonist in severe respiratory depression. Observation should extend over at least 48 hours.

Dosage forms: Tablets, 2.5 mg. of diphenoxylate HCl with 0.025 mg. of atropine sulfate. *Liquid,* 2.5 mg. of diphenoxylate HCl and 0.025 mg. of atropine sulfate per 5 ml. A plastic dropper calibrated in increments of ½ ml. (total capacity, 2 ml.) accompanies each 2-oz. bottle of Lomotil liquid.

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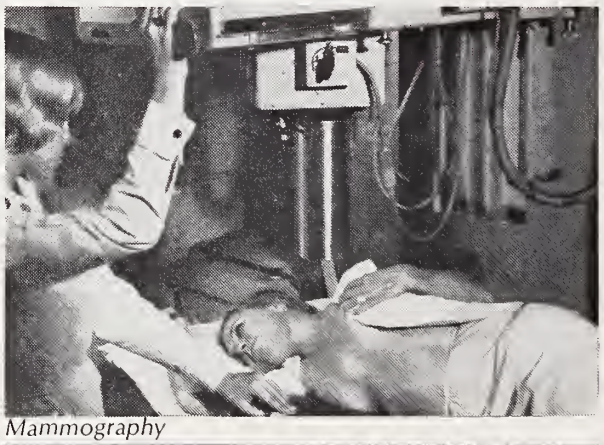
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Breast Cancer: earlier warning system

Futility and frustration beset the physician confronted with breast cancer. For the last 35 years, the survival rate has not significantly changed despite intensive educational programs aimed at earlier detection, and improvement in treatment techniques.

What is the outlook? We know the key to reducing mortality from breast cancer is in the *earliest possible* diagnosis. The stage at which breast cancer is detected is *crucial* to the outcome of treatment. By the time a lump is discovered through BSE or clinical examination, critical time may have been lost.



Mammography



Thermography

And we *do* have the means to achieve earlier diagnosis. We do have an *earlier* warning system. Mammography and thermography can detect breast cancer *before* a lump is discernible by palpation. To demonstrate that it is practical and feasible to detect breast cancer earlier by using these modalities, the American Cancer Society and the National Cancer Institute are funding a network of breast cancer demonstration projects. Supported by grants of $2-million from the ACS and $4-million from the NCI, 20 such centers are expected to be operative across the country by the end of the year. Each will screen at no charge, approximately 5,000 women annually, in what is considered to be the ideal detection program—to include clinical examination, mammography and thermography. Each of these detection methods contributes independently to the detection of breast cancer, and none can be dispensed with in the search for early disease.

At present we cannot prevent breast cancer, but the potential for saving more lives is immense. The five-year survival rate surges dramatically from 53% when axillary nodes are positive, to approximately 85% when the disease is localized, to nearly 100% for in-situ cancer.

We have an earlier warning system. Let's use it.

® american cancer society

A "Fixed" Filling Defect in the Gallbladder

W. C. LANG, M.D. *and* B. R. BAUMGARTNER, M.D., *Atlanta**

DR. W. C. LANG, JR.: This is the case of a 61-year-old female with a long history of intolerance to fatty foods and recent onset of right upper quadrant colicky pain with radiation into the right scapula area. There was no history of nausea, vomiting or jaundice. The physical examination revealed only right upper quadrant tenderness, without rebound. An oral cholecystogram was ordered. Dr. Baumgartner, what do you think of this gallbladder series?

Common Cause—Calculus

Dr. B. R. Baumgartner: The gallbladder is well opacified. An incidental finding is healing or healed fractures of the right lower ribs. The area of primary concern is a filling defect in the fundus of the gallbladder (Figure 1). The most common cause of a filling defect in the opacified gallbladder on gallbladder series would be a calculus. This filling defect stays in the same location, even though the patient's position is changed in the production of the multiple films which is part of the routine of gallbladder examination. Although this does not absolutely exclude a stone, because sometimes they can be adherent to the gallbladder wall, but most often the stone will change position in the gallbladder with the patient's change in position. The fact that the filling defect is fixed in the fundus of the gallbladder raises other possibilities.

This filling defect is smooth and in some projections there appears to be a small indentation in its central portion. There is a group of diseases that occur in the gallbladder which have been classified as hyperplastic cholecystoses. The first one of these



FIGURE 1

Oral cholecystogram. The arrows indicate a fixed filling defect in the fundus with a small central indentation.

is cholesterolosis which we think of as the pathological diagnosis of "strawberry" gallbladder. Occasionally, rather than being generalized, there can be a large collection of cholesterol in the mucosal layer of the gallbladder producing a cholesterol polyp which would be fixed to the gallbladder wall. This is a possibility.

Another form of hyperplastic cholecystoses is adenomyomatosis which is a hyperplasia of the mucosal lining of the gallbladder. There are three forms of this condition. The first type is a generalized form where the dilated glands of the hyperplastic mucosa are demonstrated throughout the gallbladder wall and have the appearance of small diverticula. These have been referred to as the sinuses of Rokitansky-Aschoff. There is a segmental form which has the same appearance as the generalized form, but is lo-

*From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, Georgia 30322. The conference material has been edited by Doctors J. L. Clements and H. S. Weens.

cated to a small segment of the gallbladder. The third form of adenomyomatosis is the solitary form which is usually in the fundus, this form as a smooth rounded configuration with a central impression which almost has the appearance of a donut.

Additional Choices

Other possibilities would include a benign neoplasm of the gallbladder wall such as papilloma. Another possibility would be early carcinoma of the gallbladder wall which would probably present as a fixed filling defect with more irregular margins. It is also probable that the gallbladder would not function well if the wall were involved with carcinoma.

I feel this lesion of the gallbladder most likely represents the solitary form of adenomyomatosis, based on its almost characteristic configuration.

Dr. H. S. Weens: You mentioned carcinoma. You are quite right that carcinoma may be detected this way, however, it is exceedingly rare that carcinoma of the gallbladder is detected on gallbladder series. Statistically speaking, chances are extremely slim that carcinoma of the gallbladder would be picked up on oral cholecystogram. Apparently the gallbladder ceases to function quite early in this disease. I would give this possibility the very last consideration.

Frequently when small filling defects of the gallbladder wall are detected the question comes up does the patient really need surgery? If the incidence of carcinoma with these filling defects were higher then surgery would be indicated without any other consideration, however, this is not the case.

Dr. Lang: In this case, the patient's symptomatology was considered the indication for gallbladder surgery. The patient underwent cholecystectomy. Dr. Baumgartner is quite right, this lesion did in fact, represent the solitary form of adenomyomatosis. The gross specimen demonstrates a localized thickening in the gallbladder wall. The histological section (Figure 2) demonstrates the characteristic hyperplasia of the mucosa and muscularis of the gallbladder at the level of the lesion with the characteristic overgrowth of glandular tissues extending through the muscular layer to the subserosal layer of the gallbladder.

Comment

Adenomyomatosis is one of the more common forms of a group of entities known as the hyperplastic cholecytoses. These entities represent hyperplasia of the various tissue elements of the gallbladder; there may be overlapping or concomitant cholecystoses in the same patient. Cholesterolosis and adenomyomatosis are the two most commonly seen and diagnosed by the radiologist.

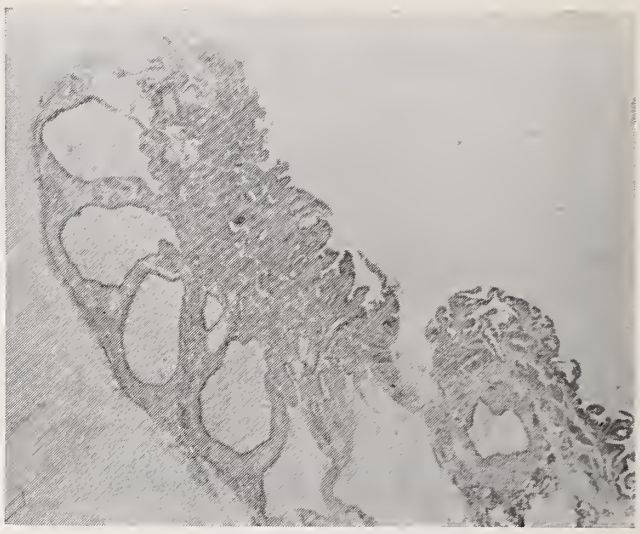


FIGURE 2

Histological section demonstrating hyperplasia of the mucosa and muscularis with overgrowth of glandular tissue extending to the subserosa characteristic of adenomyomatosis.

Adenomyomatosis consists of proliferation of the epithelium, increased thickness of the muscle layer and outpouchings of mucosa into and/or through the muscularis (so-called Rokitansky-Aschoff sinuses). Depending on the extent of involvement, adenomyomatosis is subdivided into generalized, segmental or localized type.

Radiographic appearance depends on angle of projection and extent of involvement. The generalized type is usually diagnosed by visualization of the mucosal outpouchings giving a beaded appearance. The segmental and localized types may give a similar appearance, but to a smaller extent. The segmental type may also cause a localized area of constriction to the gallbladder. The localized type may also present as a solitary, fixed filling defect in the gallbladder, often with a central area filled with contrast as in this case. The central filling defect is the area of mucosal invagination.

The exact clinical significance of these entities is somewhat unclear. Jutras feels that finding such an entity in a symptomatic patient without stones should be subject to the same discrimination and clinical judgment as when one finds a stone-filled gallbladder in the asymptomatic patient. ■

REFERENCE

1. Jutras, J. A.: Hyperplastic cholecystoses; *AJR* 83:795, 1960.

Highlights of AMA House of Delegates Actions

The AMA House of Delegates elaborated on its policy position on Professional Standard Review Organizations (PSRO) during the 27th Clinical Convention of the AMA in Anaheim, California, December 1-5, 1973. The House also addressed itself to problems arising from federal wage and price controls over health care providers, as well as numerous other issues of concern to physicians and the public.

Other issues considered ranged from malpractice problems to proposed improvements in health care delivery for migrant workers, and the method of election —and terms of service—of members of the Board of Trustees.

A total of 10 resolutions concerning the PSRO Law were introduced during the clinical session, more than for any other item of business; this indicates the high degree of concern over the issues surrounding PSRO and professional peer review.

PSROs

Reference Committee A, which began its hearings on PSRO shortly before noon Monday, December 3, heard more than four hours of testimony from physicians expressing various shades of opinion, and did not complete its preliminary report until the early morning hours of Tuesday.

After more than two hours of additional discussion on PSRO's on Wednesday, the House of Delegates adopted Report EE of the Board of Trustees, as amended, in lieu of the various resolutions which had been submitted. The report summarized PSRO developments to date, and outlined previous AMA policy in confronting the PSRO issue.

The House adopted the following amendment to be inserted on page 3, line 16, of Report EE of the Board of Trustees and Council on Medical Service:

The AMA affirms the following principles:

1. That the medical profession remains firmly committed to the principle of peer review, under professional direction, and

2. That medical society programs of proven effectiveness should not be dismantled by PSRO implementation, and

3. That the Association suggests that each hospital medical staff, working with the local medical society, continue to develop its own peer review, based upon principles of sound medical practice and documentable objective criteria, so as to certify that objective review of quality and utilization does take place; to make these review procedures sufficiently strong as to be unassailable by any outside party or parties; and that the local and state medical societies take all legal steps to resist the intrusion of any third party into the practice of medicine, and

4. That this House of Delegates, as individual physicians and through the Board of Trustees and its Council on Legislation, work to inform the public and legislators as to the potential deleterious effects of this law on the quality, confidentiality and cost of medical care; and the hope that the Congress in their wisdom will respond by either repeal, modification, or interpretation of rules which will protect the public.

The considered opinion of this House of Delegates is that the best interests of the American people, our patients, would be served by the repeal of the present PSRO legislation. It is also believed that this is consistent with our long-standing policy and opposition to this legislation prior to passage.

In adopting the above amendment, the House made special note that the last paragraph of Report EE remains the same. The last paragraph reads:

> The considered opinion of the Board of Trustees and the Council on Medical Service is to recommend to the House of Delegates that the AMA continue to exert its leadership and support constructive amendments to the PSRO law, coupled with continuation of the effort to develop appropriate rules and regulations. (Report EE adopted as amended)

Phase IV Wage-Price Controls

Four resolutions and two reports were introduced dealing with discriminatory Phase IV wage-price controls on health care providers and institutions. The House approved a Board of Trustees Report announcing AMA support for the American Hospital Association in its battle against proposed controls over acute care hospitals. Delegates also adopted a substitute resolution which directs the AMA to continue, "as a matter of high priority," to seek relief for physicians from wage-price controls "using all available administrative resources," and that "the Board of Trustees be authorized to institute appropriate legal action when so advised by legal counsel."

Physicians and Hospitals and Medical Schools

Pre-Admission Certification: The House considered two resolutions dealing with proposed government regulations which would impose a hospital pre-admission certification program for patients under Medicare. Resolution 48, adopted by the House, directs the AMA to take all steps necessary to prevent enactment of regulations mandating hospital pre-admission certification, and to determine whether such regulations would be in violation of Medicare law.

Another Resolution, #68, which would have the AMA request the Secretary of HEW not to allow the publishing of pre-admission certifications in the Federal Register, and also would have the AMA seek Congressional support for this position, was referred to the Board of Trustees and the Council on Legislation.

Funding Medical Education: Report C of the Board of Trustees, which outlines continuing AMA efforts to

secure balanced funding for medical education and research, was adopted by the delegates. The report describes several studies of the cost of medical education and its relation to the cost of medical care that are presently underway, and points out that the Council on Medical Education is closely monitoring the results of such studies with a view toward future actions.

Quality Assurance Program: After considerable discussion, the House adopted a resolution that offers the American Hospital Association the cooperation of the AMA in deliberations on the AHA's Quality Assurance Program. The AMA will seek the elimination of features it considers undesirable. A final resolve puts the AMA on record as disapproving of QAP in its present form.

Physicians and the Public

Health of Migrant Workers: Development of a possible nationwide health insurance program for migrant workers is one of several proposals contained in Council on Medical Service Report C approved by the House.

The report states that such an insurance program is possible, and adds that there is a need for migrant health advocates, who would be paid for their services rather than be volunteers.

Under action taken by the House, the Council on Medical Service is instructed to develop a version of such an insurance program.

Confidentiality of Records: The House adopted Report D of the Council on Medical Service which describes efforts to find practical solutions to problems related to maintaining the confidentiality of patient records. The House further instructed the Council to prepare model legislation to preserve confidentiality as a guide to possible state legislation. Also adopted was Resolution 41 which puts the AMA on record in opposition to violation of the confidentiality of patient records by government agencies under all circumstances.

Alcoholism: Under Resolution 30 adopted by the House, the medical treatment and admission of alcoholics would be improved. The resolution recommends to the American Hospital Association that it urge member-hospitals to liberalize admission policies for alcoholics where necessary; urges physicians to abstain from using the names of other pathological conditions in lieu of alcoholism, urges the Joint Commission on Accreditation of Hospitals to implement the intent of the Resolution as one of its requirements for approval, and urges insurance companies and prepayment plans to remove unrealistic coverage limitations for treatment of alcoholics.

National Blood Program: The concept of the proposed AMA plan to implement the government's National Blood Policy by organizing blood banks and transfusion facilities within a national system that retains regional and local responsibilities and authority was endorsed by the House. The AMA plan was contained in Board of Trustees Report Z adopted by the Delegates.

Definition of Death—Because of complex legal ramifications, the House adopted a policy position that at present the statutory definition of death is not desirable or necessary, that state medical associations urge their legislators to postpone enactment of definition of death statutes. The House also affirmed the following statement: "Death shall be determined by the clinical judgment of the physician using the necessary available and currently accepted criteria."

The Dying Patient: The House adopted the following statement to serve as a guideline for physicians confronted with ethical problems related to euthanasia (mercy killing) and death with dignity:

> "The intentional termination of the life of one human being by another—mercy killing—is contrary to that for which the medical profession stands and is contrary to the policy of the American Medical Association.
>
> "The cessation of the employment of extraordinary means to prolong the life of the body when there is irrefutable evidence that biological death is imminent is the decision of the patient and/or his immediate family. The advice and judgment of the physician should be freely available to the patient and/or his immediate family."

Specialty Representation in House: The House took several actions related to direct representation of national medical specialty societies in the House of Delegates. The House adopted a report of the Council on Constitution and Bylaws calling for a thorough study of the proposal, including an open hearing at the 1974 Annual Meeting. Two resolutions, both calling for the rejection of direct representation by the specialty societies, were referred to the Council on Constitution for consideration in its study.

Professional Liability: Report DD of the Board of Trustees, which summarizes the development of the new Medical Liability Commission formed by the AMA, and AHA, and several national medical specialty organizations, was endorsed by the House. Delegates further directed that the Board of Trustees "grant the highest priority for financial and organizational support" for the commission.

The Board of Trustees will request that the Commission give some priority to basic research in the field of medical liability, and will urge the present Secretary of HEW to consult and cooperate with the commission.

The action also puts the House on record as urging all delegates, state and local medical associations, and other medical organizations to support the new commission, and to submit to it any appropriate comments, suggestions or ideas for easing malpractice problems.

Renal Dialysis: Acting on Report J of the Council on Medical Service on several resolutions, the House adopted a strong policy position on renal dialysis and transplant procedures under Medicare. The report and resolutions objected to the "interim regulations" issued by the federal government in respect to renal dialysis and transplant under Medicare, since the regulations establish what is tantamount to a maximum fee schedule on a national basis for professional services, and in effect dictate on a national scale the method by which certain kinds of medical care are rendered.

Under actions taken by the House, the AMA will strongly protest—and seek to rescind—the interim regulations; request that the federal government return to existing systems of determining medical necessity for treatment and setting fees; and—with consultation from concerned medical specialty societies—work with the government in redrawing the interim regulations. ■

editorials
editorials
editorials

Just a Little Aesthetic Plastic Surgery

WITH THE JANUARY 1974 ISSUE, we are introducing a new "dress" for the Journal which we hope will reflect the contemporary content of the material inside and stimulate our readers to spend more time with us each month.

The functions of the Journal will not be changed nor will the general content: to serve as the official record for Association activities and business; to provide a vehicle for the publication of scientific and special articles by Georgia physicians; and to keep our members informed of the activities of their peers, the workings of government at all levels as it involves the practice of medicine and developments in the many areas which relate to health care delivery.

But we felt the pages needed a little dusting off and updating so that the message of the relevancy of its content to medical practice could come through a little more clearly. The old logo, hand-lettered and a monument to the art of calligraphy, has been familiar to readers since January 1959. The designs for our specialty pages, such as the scales of the Legal Page, have been used since 1962. Other elements of the Journal's typography have undergone gradual metamorphosis, but at this point we felt a general re-design was needed.

"Eurostyle" is the name of the type used for our cover logo which spells out "Georgia" in bold, san-serif letters. This same type has been picked up and used throughout the Journal to make it simple for you to find the "Contents," "Editorials" and "Cancer Page." This is just a sample of the details which have been considered and revised for 1974. Look everything over and let us know your reactions.

Confused by Page Numbers?

This may be the time to explain the page numbering system used in the Journal, which has been known to confuse our readers. There are two separate systems, one for advertisements and one for editorial material. This is done for ease in indexing and binding. In general, advertisements are restricted to the front or the back of the Journal. These pages, with each new issue, begin with 1A through approximately 12A in the front, then pick up with 13A to 24A or so in the back. When there is no number on an advertising plate, it is because the plate from which it is printed does not allow room for a number. The editorial material, however, is numbered consecutively throughout the year. The January issue will include pages 1 through 30, February will pick up with the pages 31 through 60, approximately, etc.

Sometimes an advertisement interrupts an article unavoidably. The "center of the journal" space, for example, is a prime advertising position which is

purchased at an additional charge. Other ads also come to our printer as pre-printed inserts which can be "tipped in" only at specific points in the magazine body. If there are large numbers of inserts for one issue, some will have to be used within the editorial material.

If you have been confused by some aspect of the Journal's makeup, let us know. We hope we can give you a logical explanation for it. We also hope you find the changes pleasing to the eye and more convenient to your busy schedule which allows little time for the luxury of browsing.

EW

GaMPAC & You = Effective Political Action

IT HAS BECOME INCREASINGLY evident to me that physicians are more aware of the necessity for political involvement now than at any time in our past.

Even though a look at history informs us that there were five physician-signers of the Declaration of Independence and that there have been many physicians elected to public office, it is not necessary to be "elected to be effective."

Avenue of Political Adventure

GaMPAC is a state-wide, voluntary, non-profit group whose membership consists of physicians, their spouses and members of allied medical professions. It is an avenue of exciting political adventure on which you can travel at your own rate of money and time expenditure. But watch out—the virus of politics is contagious and you may become an intermediary host and pass it on to your colleagues. Involvement is the drug of choice in treatment.

In less than a year we will find ourselves in the midst of electing 435 members of the U.S. House of Representatives, one third of the U.S. Senators, 35 state governors and hundreds of state legislators. Political scandals which have rocked the nation at every governmental level and in both parties, are enough to turn away the novice and even demoralize the most seasoned political enthusiast. The cynics are grateful for this ready-made excuse to dodge their civic responsibilities and to use the scandals as their reason for inactivity.

These scandals should not be a reason to avoid political action, but a reason to become involved politically. Now more than ever we must use the avenues and opportunities unique to our system to leap into the contest, and by our own dynamic action, help to bring forth positive change. Constructive change can occur when problems are viewed positively as challenges, and crises are viewed optimistically as opportunities for creative change.

Politics will not permit a laissez-faire attitude or course of action. GaMPAC is a proven method of evaluation in deciding whether or not to contribute to a candidate.

Evaluating a Campaign

The primary aspects of a campaign which are evaluated are: 1) the degree of active and financial support on the part of local physicians for the candi-

date; 2) the disposition of the candidate toward giving organized medicine's view a fair hearing; 3) the candidate's chance for success; 4) the degree of professionalism in the campaign; 5) the need of the candidate for additional political funds and his desire for contributions from organized medicine.

Membership's dollars come from you, your families and your colleagues, and this important contribution is very significant in the activities of GaMPAC. Without you, it will not work. Make sure your first political contribution this year is to GaMPAC. You owe it to yourself, your profession and your state to support the medical political action movement.

Politics is not something to avoid or abolish or destroy. It is a fact of life. It is something to live, to influence if we wish, and to control if we can. We must master its ways or we shall be mastered by those who do.

J. Dan Bateman, M.D.
Chairman, GaMPAC

Questions and Answers

The following questions and answers concern the Medical Association of Georgia's adoption of the Southern Medical Association Group Insurance Program and represent those asked most frequently.

Q. Why did the Insurance Committee of the Medical Association of Georgia recommended acceptance of this plan?

A. The Southern Medical Insurance Plan offers the most coverage for the premium dollar, and was the one group who would accept ALL of those insured under the other MAG plan, regardless of age or insurability.

Q. Has the transfer of coverage been effected in an orderly manner?

A. Yes, the transfer has worked well. There have been problems, but the spirit of cooperation with which these problems have been solved has been terrific.

Q. Did the previous insurance carrier cooperate in this conversion?

A. Yes. The Life Insurance Company of Georgia has been most cooperative in every way. We should be most generous in our endorsement of this company and the individuals who work for it.

Q. Are all MAG members eligible for this insurance?

A. Those members who are under 60 years of age and who are insurable can get this coverage. SMA maintains a strict underwriting policy to keep premiums low.

Q. Just what is offered to the physician under this new plan?

A. Life insurance (up to $60,000)
Accidental death and dismemberment (up to $150,000)
Long-term disability income (up to $1,500 per month)
One-year disability income (up to $1,500 per month)
Major hospital insurance (up to $100,000 per physician) $300 or $500 deductible, then 80 per cent of hospital and nursing expenses. This same coverage available for eligible family members.
Office overhead expense disability insurance (up to $1,500 per month)
AND life insurance, accidental death and dismemberment, and major hospital as described above for the physician's employees.

Q: Is membership in the Southern Medical Association a requirement for this coverage?

A. Yes, the physician must be a member or associate member. The Southern Medical Association dues are $30 per year and membership is by invitation to physicians who are eligible to be members of the following state medical societies: Alabama, Arkansas, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia.

Q. Is the Medical Association of Georgia represented in the Southern Medical Association insurance program?

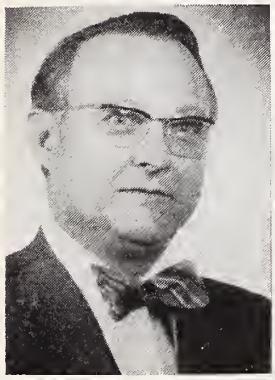
A. Yes! William W. Moore, Jr., M.D., chairman of MAG's Insurance and Economics Committee, is now a member of the Southern Medical Insurance Committee.

Q. If I desire to subscribe to this plan, how do I get the brochure, information about the Southern Medical Association, the insurance carrier, Connecticut General Insurance Company, i.e., the information necessary to become insured?

A. Simply call the Southern Medical Association (817) 335-6571 in Fort Worth, Texas asking for Miss Pat Pridemore, or call on the MAG WATS line (800) 282-0224 asking for L. B. Storey.

president's letter

The Voice of the Grassroots Practitioner



THE AMA CLINICAL SESSION convened in Anaheim, California last week (December 1-5, 1973). Your Georgia delegation was again somewhat short-handed, but we managed to have someone attend all reference committee hearings and report back to the caucus meetings of the delegation the following a.m.

Professional Standards Review Organizations was the topic of greatest concern for the delegates. Pro and con presentations before the reference committee were always sincere, sometimes prolonged, often well-prepared and well-presented, and sometimes more emotional than realistic; but everyone had his chance to say his piece.

To me, the most impressive facet of our AMA or MAG meetings is the undeniable sincerity of the participants. All are primarily interested in the past, present and future of the practice of medicine. This interest begins on a local level and usually reflects the thinking and beliefs of one's colleagues. More physicians are members of local medical societies than of societies above the local level. A physician-member of a local society benefits or suffers from the actions of higher level societies by virtue of his influence on his local society delegate to the higher society meetings. This, I feel, has not been stressed often enough on a local level.

Many physicians who are represented at MAG or AMA meetings are therefore not members of MAG or AMA, but their influence is there. This, to me, is what is meant when we hear the words, "These are the wishes of the grassroots practitioner." I feel that "grassroots practitioners" must continue to let their voices be heard, they all should become more involved and should strive to improve, mold and influence organized medicine rather than to criticize it. I do not feel physicians can live in the framework of union or union-like organizations. I feel we should make our current organization more responsive to our wishes and convictions and not strike out in many opposite and diverse directions.

We of the Executive Committee, Council and headquarters staff wish for Mrs. Perk Chambers, the wonderful wife of J. W. "Red" Chambers, our senior delegate to the AMA, a rapid recovery from her illness.



Charles Emory Bohler, M.D.
President, Medical Association of Georgia

1974 MAG Business Session and Auxiliary Annual Session Schedule

MAG

Friday, May 10

8:30 a.m.	Registration Opens
9:00 a.m. to 12:00 noon	Opening Session and House of Delegates Reference Committees

Saturday, May 11

10:00 a.m. to 12:00 noon	GaMPAC Brunch
12:00 noon to 1:00 p.m.	General Session (Memorial Service, Awards, etc.) President's Reception

Sunday, May 12

9:00 a.m. to 12:00 noon	House of Delegates and Final Session (Elections, Reference Committee Reports and Officer Installation)

AUXILIARY

Thursday, May 9

4:00 p.m. to 5:00 p.m.	Pre-Convention Board Meeting

Friday, May 10

8:30 a.m. to 5:00 p.m.	Registration
11:00 a.m. to 1:00 p.m.	General Meeting
1:00 p.m. to 2:00 p.m.	Awards Luncheon

Saturday, May 11

8:30 a.m. to 10:00 a.m.	Past Presidents' Breakfast
11:00 a.m. to 12:00 noon	General Meeting
1:15 p.m. to 3:00 p.m.	Installation and 50th Year Luncheon
3:00 p.m. to 5:00 p.m.	Post-Convention Board Meeting

Medical Association of Georgia
Business Session

MAY 10-12, 1974—Savannah, Georgia

RESERVATION INFORMATION

1. Please complete this form and mail to: Reservation Department
   (Motel or hotel of your choice)
   Savannah, Georgia
2. Special reservation forms will be mailed by MAG Headquarters Office to officers, councilors and delegates for rooms at the DeSoto Hilton Hotel.
3. Assignment of rooms will be made in order of receipt of reservation by other hotels listed. If possible, confirmation will be in accordance with preference indicated; if not, best substitute will be made.
4. Unreserved accommodations will be released on April 20, 1974.
5. Rooms will not be ready for occupancy until 1:00 p.m. on day of arrival. Check-out time is 1:00 p.m. on your departure date.
6. Other members (not in categories named in (2)) may make reservations at below listed hotels if you desire to attend this Business Session.

DAILY HOTEL/HOTEL ROOM RATES—EUROPEAN PLAN (Meals not included)

Downtowner Motor Inn: 201 W. Oglethorpe Avenue (233-3531).
Single, $15; Twin/Double, $20.
Holiday Inn: 121 W. Boundary Street, on U. S. No. 17 at Talmadge Bridge (236-1355).
Single, $12; Double, $16; and Twin, $18.50.
Ramada Inn: 231 W. Boundary Street (232-1262).
Single, $14; Twin/Double, $18.

Cut out and send to motel/hotel of your choice:

Please type or print

Please reserve from block of rooms being held for:

MEDICAL ASSOCIATION OF GEORGIA

MAY 10-12, 1974

NAME .....

ADDRESS .....

CITY AND STATE ..... **ZIP** .....

ARRIVAL DATE ..... **DEPARTURE DATE** .....

TYPE OF ACCOMMODATIONS DESIRED ..... **FOR** ..... **# OF PERSONS**

Cervical Cancer: Detection, Diagnosis and Treatment

ERNEST W. FRANKLIN, III, M.D., *Atlanta**

CURRENT STATISTICS, INCLUDING those from the Third National Cancer survey, suggest that death rates due to cancer of the cervix have been declining in areas in which the eligible female population has been screened by the Pap smear and optimal treatment facilities have been available. And yet, on a nationwide basis only 50 per cent of the eligible population has ever had a Pap smear. The state of Georgia continues to have one of the highest death rates due to cervical cancer. In order to reverse these sad figures and realize the potential for control of cervical cancer with the realization that "early cancer usually can be cured," three areas must be emphasized: detection, diagnosis and treatment.

Population at Risk

Detection, the identification of the population at risk who are suspected of having cervical cancer, must emphasize more widespread utilization of the Pap smear, particularly on the asymptomatic patient. To this purpose, the American Cancer Society at the national, state and local level has organized a task force on uterine cancer, often working in conjunction with a task force on breast cancer, to promote the objective of extensive screening of the symptomatic and asymptomatic patient by cervical cytology. This objective has been endorsed by the Medical Association of Georgia and will require the support and participation of its membership.

The cytology cannot serve as a means of diagnosis and only detects a patient at risk of cervical cancer. Subsequent to an abnormal cytology, the objective is to devise a means of determining the precise nature and extent of disease with the least risk and expense to the patient and the greatest accuracy in defining the nature and extent of disease, certainly with the lowest risk of leaving undetected the presence of invasive cervical cancer. Past practice has often included the widespread utilization of conization of the cervix to define the extent of disease.

The benefits of obtaining a larger block of tissue for evaluation must be weighed against the expense and potential morbidity of the procedure, including dysmenorrhea, cervical incompetence and hemorrhage. In pregnancy the procedure has been particularly hazardous with a 20 to 30 per cent morbidity for mother and infant, including extensive hemorrhage and premature labor. Observations on the behavior of cervical neoplasia, including the malignant precursors (dysplasia) have established that the zone of maximum risk is the interface at which the squamous and columnar cells meet, the squamo-columnar or transformation zone. Careful observation and biopsy of this area, including the use of the Schiller stain plus

*Co-chairman of the Breast-Uterine Cancer Task force of the American Cancer Society, Georgia Division, Inc. Dr. Franklin may be contacted at the Emory University Clinic, 1365 Clifton Road, Atlanta 30322.

curettement of the endocervical canal, accomplished on an outpatient basis can exclude the necessity for conization in the majority of patients with an abnormal cervical cytology.

Colposcope Provides Precision

Greater precision in diagnosis can be obtained utilizing the colposcope, an instrument providing binocular observation of the cervix at 15 to 30 X magnification. Observation of the squamocolumnar junction or transformation zone with this instrument allows identification of morphologic changes (color, vascularity, texture) characteristic of both premalignant and malignant states. With the utilization of the colposcope, 75 to 80 per cent of patients with an abnormal cervical cytology can be evaluated without conization of the cervix. The importance of unnecessary conization should be stressed as much as seeking improvement in detection of cancer in the patient whose Pap smear may have revealed an atypical or equivocal picture despite the presence of invasive cancer. Delay in diagnosis is thereby avoided.

Finally, it becomes the responsibility of the medical community to provide leadership in assuring the optimum quality of medical care for the patient stricken with invasive cancer. Optimum utilization of current knowledge and technology regarding the treatment of cervical cancer could significantly improve the survival rates of those stricken with cervical cancer, perhaps 10 to 15 per cent. Improved systems of delivery of this care, including training of physicians and allied health personnel and development of regional facilities deserves continued emphasis. ■

"A Day of Cancer"

TUESDAY, MARCH 5, 1974
Stouffer's Inn, Atlanta

PRESENTED BY:	Atlanta Graduate Medical Assembly American Cancer Society, Georgia Division, Inc.
TO INCLUDE:	Lectures and discussion on use of adjuvant therapy in management of primary breast cancer . . . surgical treatment of metastatic cancer . . . radiation therapy in the management of localized cancer of the prostate . . . treatment of melanoma . . . choice of treatment for squamous cell carcinoma of the oral cavity . . . chemotherapy for advanced gastro-intestinal tumors . . . radiation therapeutic approach to cancer of the cervix . . . primary surgical management of breast cancer.
GUEST FACULTY:	Lemuel Bowden, M.D., New York, N. Y. Bernard Fisher, M.D., Pittsburgh, Pa. Richard H. Jesse, M.D., Houston, Texas Carlos Perez, M.D., St. Louis, Mo. William Shingleton, M.D., Durham, N. C.
FOR INFORMATION AND REGISTRATION WRITE:	American Cancer Society, Georgia Division, Inc. 2025 Peachtree Road, N.E.—Atlanta, Ga. 30309 Telephone No.: (404) 351-3650 or Atlanta Graduate Medical Assembly 875 West Peachtree St., N.E.—Atlanta, Ga. 30309 Telephone No.: (404) 875-1062

Cancer Seminar on Chemotherapy, Immunotherapy and Radiation Therapy

MARCH 22 AND 23, 1974
Holiday Inn, Callaway Gardens, Pine Mountain

PRESENTED BY:	American Cancer Society, Georgia Division, Inc. Committee on Cancer, Medical Association of Georgia Enoch Callaway Cancer Center, Inc., LaGrange, Ga. Medical Center, Columbus, Ga.
TO INCLUDE:	Lectures and discussion on chemotherapy, radiation therapy, immunotherapy and surgery in the management of lymphomas, soft tissue sarcomas, solid tumors, cancer in children, and radionuclides in the diagnosis of cancer.
GUEST FACULTY:	Alex Green, M.D., St. Jude's Hospital, Memphis, Tenn. Paul B. Chretien, M.D., National Cancer Institute, Bethesda, Md. Edward T. Krementz, M.D., Tulane University, New Orleans, La. James H. LaRose, M.D., Emory University, Atlanta, Ga. Thomas Pomeroy, M.D., National Cancer Institute, Bethesda, Md.
FOR INFORMATION AND REGISTRATION WRITE:	American Cancer Society, Georgia Division, Inc. 2025 Peachtree St., N.E. Atlanta, Ga. 30309 Telephone No.: (404) 351-3650

Postgraduate Course in Neoplasia of the Female Genital Tract—Pathogenesis, Diagnosis and Treatment

APRIL 8, 9, 10, 1974

PRESENTED BY:	Division of Gynecologic Oncology, Department of Gynecology and Obstetrics, Emory University School of Medicine.
TO INCLUDE:	A two-day seminar on carcinoma of the cervix, endometrium, vulva and ovary Workshops on carcinoma of the ovary and endometrium A one-day course in colposcopy, basic and advanced, with lecture, instruction and patient demonstration
GUEST FACULTY:	John Frost, M.D., Baltimore, Md. James W. Regan, M.D., Cleveland, Ohio Ralph Richart, M.D., New York, N. Y. Adolph Stafl, M.D., Ph.D., Milwaukee, Wis. Duane E. Townsend, M.D., Los Angeles, Calif.
FOR CATALOGUE AND APPLICATION WRITE:	Division of Continuing Education Department of Gynecology and Obstetrics Emory University School of Medicine 69 Butler St. Atlanta, Ga. 30303 Telephone No.: (404) 659-0289

legal page
legal page
legal page

Letters From Another Century

J. WINSTON HUFF, *Atlanta**

FOR ABOUT EIGHTEEN MONTHS I have supplied the Legal Page for the *Journal.* On looking back it appears that many, if not most, of these articles contained bad news—malpractice developments, new adverse tax laws and alarums of various sorts. I thought, good reader, you and I both deserve a breather, especially after the Christmas season. So here it is.

Recently I came across a batch of letters written by my grandfather while he was a student at Tulane University Medical School. I have extracted from these letters a few passages which I thought might be interesting or amusing to today's physician.

My grandfather, George H. Winston, M.D., was born in 1866 and entered medical school in 1887, graduating in 1889. These letters were written from New Orleans, Louisiana to his grandfather and grandmother, who reared him.

October 11, 1887

I matriculated this morning and then went to the hospital. . . . I have a beautiful case of dissecting instruments that cost me $6.00. Tell Aunt Mollie that they "pickle" their subjects here, so she need not buy over a gallon of perfume to prepare for my return home. The boys who attend here look, for the most part, rather rough. They are what the boys at Athens denominated "scrubs."

October 17, 1888

I arrived here in safety this morning. I had to swear a quarantine oath about every other station, though. They have no yellow fever here and they do not intend to have any. I do not believe that I would have gotten through had it not been for my health certificate.

October 27, 1888

I had a good run of luck today. Professor Elliott quized me for an hour and ten minutes, as is his habit when he has no cases to show, and I did not break down on a single question. When the professor has no new patients in his ward, he will take some boy and continue to quiz him until he breaks down. Then he explains whatever the boy broke down on and calls up another boy and so on. Well, he used up his whole time without breaking me, though he scared me badly enough.

November 4, 1888

Ask Aunt Mollie if she will sell me her opera glasses. The present medical class

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*Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, Atlanta, Ga. 30303.

is so large that I am often unable to get close enough to an operation to tell anything about it. If she will let me have them, you might send them to me in a box of eatibles.

November 14, 1888

I am very sorry to hear of all the sickness at home. I would not advise that Aunt Mollie sleep in the same room with Lula. Have the room disinfected. Shut the door and windows, build a fire in the fireplace and heat a kettle of water on the fire so that the steam will escape into the room. At the same time, burn two or three pounds of sulfur in a box of sand in the middle of the room. Keep the room thus closed for six or eight hours.

November 18, 1888

How did Lula contract diphtheria? We hold to the germ theory now and claim that there must be contagion, though this is disputed by many eminent writers.

Asa Griggs has paid me a visit of two days while on his way to Texas. He left last night. He says that Texas is the best country in the world to live in. His chief business here was, I believe, to buy a bunch of bananas and ship them to a young lady living near Milledgeville.

November 27, 1888

I am now especially interested in three fever patients, all of whom were workmen on the Panama Canal at which place they contracted an exceedingly malignant form of malarial poisoning. I think that two of them will get well but I do not expect to see the other one when I return to the hospital tomorrow morning. By the way, I have a curious case in one of the surgical wards. It is one of a man, a Malay, who had some time ago a large portion of diseased bone (necrosis of the tibia) removed from his shin just above the ankle. There are natural openings and openings made by the knife on both sides of his leg. Another student and myself are allowed to dress this leg and when we start to wash out the wound with an antiseptic solution applied by a douche, the water often shoots clean through and spouts on the other side. Now when I say "curious case," I mean the Malay, not the affected part. He can not speak a word of English and when that water spouts through his leg he seems to think it is the funniest thing in the world.

The people in this town are very peculiar. When one of them dies, no matter whether young or old or who, the proper thing is to hitch a brass band to the end of the procession and out to the cemetery they go to the sound of music that is not always a dirge. And another thing, is the custom of looking in at the shop windows. Ladies who apparently belong to the highest circles will collect around a window, discuss and comment on its contents for minutes at a time, and then move to the next window where the same thing takes place. Finally, without entering a single store, they get to the end of Canal Street where they board a street car and go home.

December 15, 1888

I very much wish that I could be with you all at Christmas but, of course, that is impossible. Even if I had the money, which I have not by a long sight, I could not come as they allow us but one day for holidays, Christmas Day. It is very much all work and no play with a medical student.

I am quite well at the present writing. I merely had an attack of malarial intermittent "quotidian" which I at once broke up by the free use of quinine.

I am boarding with a French family and that means good eating. I say good eating and it is. But I can't tell what it is. Dishes are brought to the table, and though in a general way one can say "this was meat and that was vegetable matter," I defy you to say what it was. But they taste well and that is as far as a medical

student's mind cares to investigate. The most usual remark heard at our table is "Dr. So and So, please pass me that something to eat by you"—this accompanied by an expressive and indicative nod.

December 20, 1888

Please tell my Aunt Mollie to send me $65.00. I am ready to hand in my thesis and that document must be accompanied by a $30.00 diploma fee. If we do not get a diploma, we get our money back. Egad! It is getting to look as though I will have either to ride home without a sheepskin or walk home with one. If the latter, I hope that I will not be a walking epidemic. If the former, home will not see me soon again. Even if I do not get a diploma, I will go to Texas and practice medicine anyhow.

January 14, 1889

I can't help feeling uneasy about graduating. It seems to me as though every new fact I learn shows me a half dozen more that I do not know and thus it goes on until I begin to wonder how anyone ever managed to pass at all. If I do not pass, I won't trouble you about any instruments. I will get a position as a street-car driver.

January 20, 1889

Please send me about $100. My board is $30.00 per month and we boys have to pay for our commencement—that is the graduating class. The faculty pays nothing. We have to hire an opera house, pay for invitations, music, etc. If I do not pass, I will need about the same, because if I do not pass, I intend to go to some backwoods place in Texas or elsewhere and practice.

January 25, 1889

I have already bought some instruments from an old M.D. who is retiring from practice. They were as good as new and so much cheaper than new ones that I borrowed the money and bought them. I will need instruments whether I graduate or not. Because, as I have said, if I do not, I am going to some out of the way hole and practice. My friend, Morris, made enough money last summer to come back here on, and if I can't do next year what he did last year I would like to know why.

February 18, 1889

Were I not completely occupied I could not stand this miserable city, with its foundation of mud, its climate more changeable than Proteus, an atmosphere of malaria, consumption, germs, smoke and fog. Day before yesterday, I wore my overcoat; last night I slept with all my windows up. It is probable that tonight I shall need a fire.

March 15, 1889

I am the most unfortunate person in existence. Only a few days ago it was Rotheln. Now it is parotitis—vulgarly called "mumps." I have it in my parotid gland upon one side and my submaxillary upon the other. My jaw aches all of the time and the worst of all I can not eat.

You will probably not hear from me again until after examinations and it may be that then I will bring news of myself in person.

(P.S. He did pass, was graduated and received his diploma.) ■

The Rx that says "Relax"

BUTISOL Sodium provides highly predictable sedative effect: minor dosage adjustments are usually all that's needed to produce the desired degree of sedation. (With 3 dosage forms and 4 strengths to make adjustments easy.)

BUTISOL Sodium offers prompt, smooth, relatively non-cumulative action: begins to work within 30 minutes...yet, because of its intermediate rate of metabolism, generally has neither a "roller-coaster" nor a "hangover" effect.

BUTISOL Sodium is remarkably well tolerated: a 30-year safety record assures you that there is little likelihood of unexpected reactions.

BUTISOL Sodium saves your patients money: costs less than half as much as most commonly prescribed sedative tranquilizers.*

These are four good reasons for prescribing BUTISOL Sodium for the many patients who need to have the pace set just a little slower. Its gentle daytime sedative action is often all that's needed to help the usually well-adjusted patient cope with temporary stress.

*Based on surveys of average daily prescription costs.

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(SODIUM BUTABARBITAL)

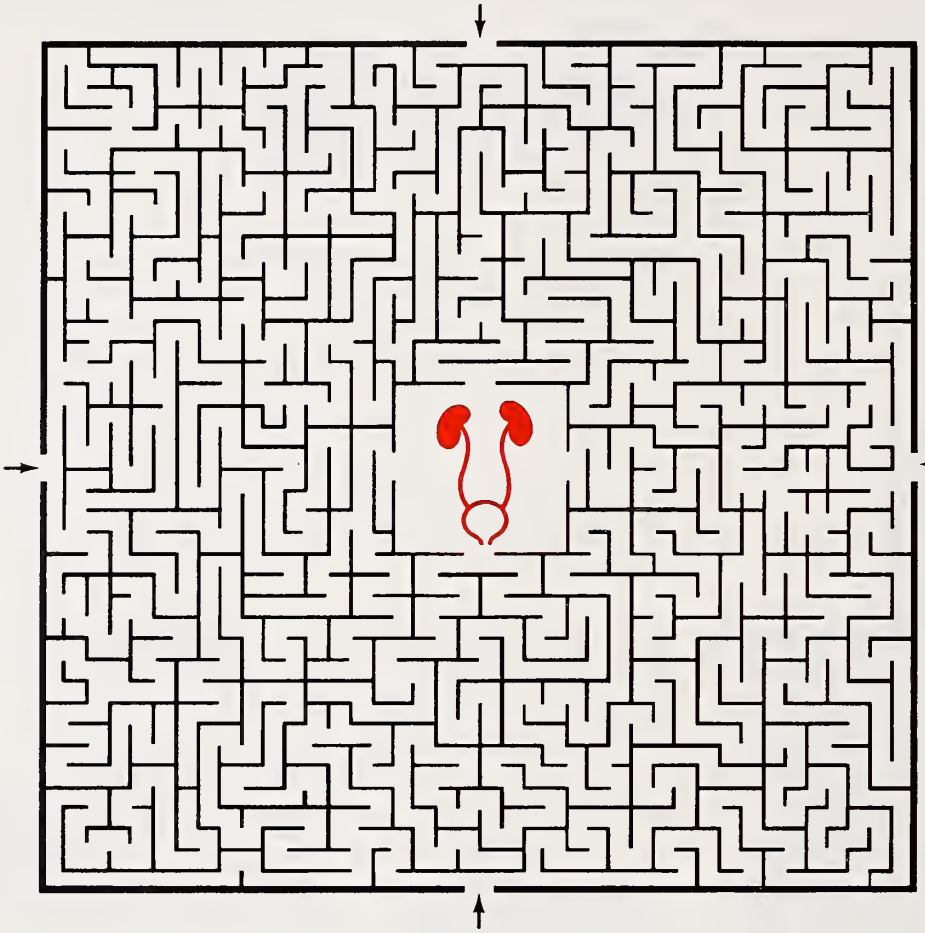


Contraindications: Porphyria, sensitivity to barbiturates, or susceptibility to dependence on sedative-hypnotics. **Warning:** May be habit forming. **Precautions:** Exercise caution in: moderate to severe hepatic disease; withdrawal in drug dependence or the taking of excessive doses over a long period, to avoid withdrawal symptoms; elderly or debilitated patients, to avoid possible marked excitement or depression; use with alcohol or other CNS depressants, because of combined effects. **Adverse Reactions:** Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and gastrointestinal disturbances are seldom seen. **Usual Adult Dosage:** For daytime sedation, 15 mg. to 30 mg. t.i.d. or q.i.d. For hypnosis, 50 mg. to 100 mg. **Available as:** Tablets, 15 mg., 30 mg., 50 mg., 100 mg.; Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg., 30 mg., 50 mg., 100 mg.

McNEIL McNeil Laboratories, Inc., Fort Washington, Pa. 19034

Basics in the treatment of urinary tract infection

Short-term therapy is no shortcut



Enter any opening and find way to center of maze. Only one entrance will get you there.

The case for adequate length of therapy

In the insidious, common and often stubborn urinary tract infections, duration of therapy is not standardized. Because renal damage in many patients is believed to result from repeated urinary tract infections in childhood, one pediatrician has stated that a rational approach to treatment includes more than a perfunctory prescription of an antibacterial agent.[1]

The first 48 hours and after...

To ensure adequate therapy, one expert[2] proceeds as follows: an initial culture and one after 48 hours. If the antibacterial used has been effective, the urine will be clear of pathogens after 24 to 48 hours. However, urine should be recultured and any persistence of original pathogens indicates that another drug be used. On the other hand, if urine is found to be sterile, the same drug is continued for two weeks. Then urine is recultured starting a week after the last drug dose, and cultures are continued monthly for three months, then every three months for a year, and finally, every four months for several years.[2]

Another authority[3] notes that initial short-term therapy without careful follow-up can lead to trouble, as reflected by the high relapse rate. He treats an initial urinary tract infection with a sulfa drug after taking a urine culture. If *Escherichia coli* is found—and it is in 70 to 80 per cent of cases—he continues full dosage for 21 days. Five to 10 days after cessation of therapy, he recultures and takes a colony count. If urine is sterile, he recultures at three and six months.

Measurement of success

For success in the treatment of urinary tract infection, the urine must be kept free of bacteria for prolonged periods until the focus of infection in the tissue has been eradicated.[3] This may take months or years when the infection is chronic or persistent. Criteria for successful therapy with a drug are regarded as absence of symptoms and absence of pyuria and bacteriuria.[3] One authority defines significant bacteriuria as a count of at least 100,000/ml of the same organism in two consecutive clean-voided urine samples.[4]

The nature of the infection and the length of therapy

Long-term follow-up is essential, a clinician who treats recurrent infections for one to two years points out.[3] Persistent, symptomless bacteriuria usually calls for urologic procedures to find the site of infection, because any underlying abnormality predisposing to urinary tract infection must be detected and corrected—otherwise therapy is futile.[5] Upper urinary tract infection generally requires longer therapy than infection of the lower urinary tract.

In acute, simple, first infections of a symptomatic type, the pathogens are nearly always *E. coli* or *Proteus mirabilis*.[5]

References: 1. Normand, I. C. S.: *Practitioner, 204*:91, 1970. **2.** Kass, E. H.: *Hosp. Med., 4*:73, 1968. **3.** Lampe, W. T. II: *J. Am. Geriatr. Soc., 16*:798, 1968. **4.** Petersdorf, R. G., and Turck, M.: *GP, 32*:(2) 130, 1965. **5.** Benner, E. J.: *Med. Times,* 98:(2) 95, 1970.



The case for Gantanol® (sulfamethoxazole)

Fights susceptible organisms most often implicated

Gantanol® (sulfamethoxazole) is effective against not only susceptible strains of *E. coli* and *Proteus mirabilis* but also of *Klebsiella-Aerobacter, Staphylococcus aureus* and, less frequently, *Proteus vulgaris*—pathogens apt to be found in the mixed bacterial flora of recurrent and chronic cystitis and/or pyelonephritis.

Prompt antibacterial blood/urine levels

After the initial 2-Gm adult dose, therapeutic blood/urine levels are usually reached in from 2 to 3 hours, then maintained with either of the two dosage forms of Gantanol—tablets or suspension. And, Gantanol *b.i.d.* dosage means up to 12 hours of antibacterial activity, obviating the patient's having to disturb his sleep to take medication. More severe infections may require *t.i.d.* dosage.

Also effective in certain nonobstructed chronic and recurrent urinary tract infections

Nonobstructed chronic and recurrent cystitis or pyelonephritis develops more commonly in the elderly and debilitated, and response to Gantanol (sulfamethoxazole) is often highly satisfactory. The usual precautions in sulfonamide therapy should be observed, including maintenance of adequate fluid intake, frequent c.b.c.'s and urinalyses with microscopic examination.

Make the therapy suit the infection

In most urinary tract infections the *b.i.d.* schedule will usually suffice, but therapy must be maintained long enough to ensure eradication of pathogens. Mounting evidence in current medical literature suggests a minimum of 14 days of continuous therapy.* Adequate treatment for a sufficient time may also help prevent possible kidney damage. Gantanol is generally well tolerated with relative freedom from complications. The most common side effects include nausea, vomiting and diarrhea. Prescribe Gantanol tablets or the pleasant-tasting suspension.

*Data on file, Hoffmann-La Roche Inc., Nutley, N.J.

In nonobstructed cystitis due to susceptible organisms

Gantanol® B.I.D. (sulfamethoxazole) Basic Therapy

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, N.J. 07110

Please see following page for summary of product information.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute, recurrent or chronic nonobstructed urinary tract infections (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms. ***Note:* Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides, especially in chronic or recurrent urinary tract infections.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Sulfonamide hypersensitivity; pregnancy at term and during nursing period; infants less than two months of age.

Warnings: Safety during pregnancy has not been established. Sulfonamides should not be used for group A beta-hemolytic streptococcal infections and will not eradicate or prevent sequelae (rheumatic fever, glomerulonephritis) of such infections. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy. Insufficient data on children under six with chronic renal disease.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *gastrointestinal reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia as well as thyroid malignancies in rats following long-term administration. Cross-sensitivity with these agents may exist.

Dosage: Systemic sulfonamides are contraindicated in infants under 2 months of age (except adjunctively with pyrimethamine in congenital toxoplasmosis).

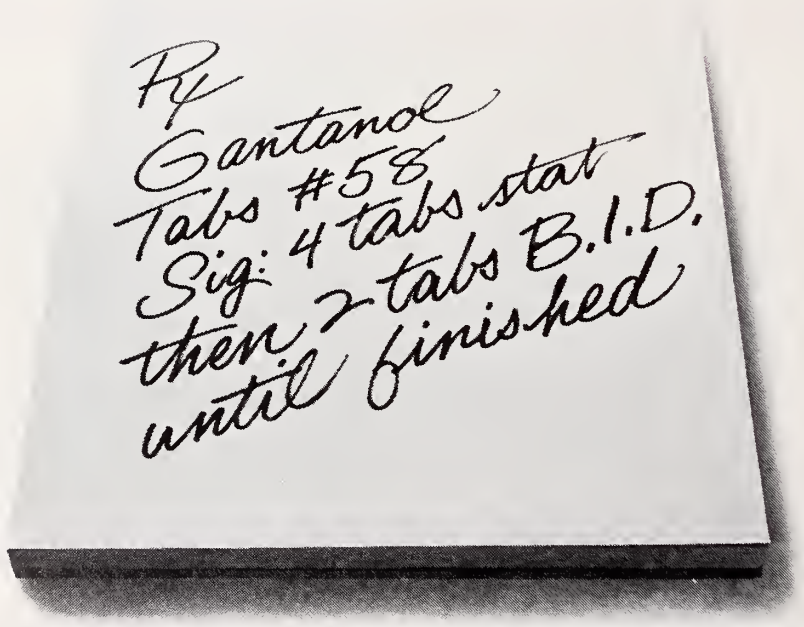
Usual adult dosage: 2 Gm (4 tabs or teasp.) initially, then 1 Gm *b.i.d.* or *t.i.d.* depending on severity of infection.

Usual child's dosage: 0.5 Gm (1 tab or teasp.)/20 lbs of body weight initially, then 0.25 Gm/20 lbs *b.i.d.* Maximum dose should not exceed 75 mg/kg/24 hrs.

Supplied: Tablets, 0.5 Gm sulfamethoxazole; Suspension, 0.5 Gm sulfamethoxazole/teaspoonful.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc
Nutley, N.J 07110



In nonobstructed cystitis due to susceptible organisms

Gantanol® (sulfamethoxazole) B.I.D.

Basic Therapy

I've told this before . . . .

(Ed. note: A mischievous, bright dog can be a lot of fun . . . until his curiosity takes him to the hen house. The adventures of one family pet with an unfortunate taste for chicken-chasing are told in the following story by J. G. McDaniel, M.D. of Atlanta. Other physicians and their wives wishing to contribute a human interest story for our pages should contact the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Freckles

WHEN THE CHILDREN WERE SMALL I bought a lovable young female dog, who had the imposing title of being a Texas Beagle. (I guess because she was larger than a Beagle should be.) The children named her "Duchess" and we had her only a few weeks when it became apparent that Duchess had known a gentleman quite well prior to becoming a McDaniel.

One of her puppies was a very bright lad who had brown freckles over a gray nose and head. He was given to some friends who had two small boys. Freckles was a great dog. He went everywhere with the children. He would snooze on the porch while dozens of cars and buses passed, but when the school bus stopped at the corner, he was awake and off like a flash to meet them. The same was true of the family cars. If a strange person or car came into the drive-way or yard he would "sound off."

The boys' father, John Greenfield, loved Freckles also and taught him one trick which he was very proud of, that being to "roll over."

Then one Saturday a very unpleasant thing happened—a neighbor came rushing to their home and said that Freckles was in his chicken yard killing his hens. They went up there and sure enough Freckles was having the time of his life, chasing hens, catching them, playing with them a little too roughly—but making no effort to eat one. This little escapade upset Mr. Greenfield as well as costing him $25.00. He realized that as smart as Freckles was, he would figure out some way to get back in that yard and play with those chickens again.

While they were debating about what to do—Freckles disappeared. Neighborhood searches, phone calls, ads in the paper were of no avail.

Freckles was forgotten until about 18 months later. When the family returned from church one Sunday morning, a dog looking very much like him was asleep on the front porch and greeted them enthusiastically as they got out of the car. He was a different looking dog however, he looked much older, had scars on his nose and ears, evidently from fights. He had lost weight. Some of the family thought he was Freckles, some not. Finally, Mr. Greenfield said that he could settle it. Requesting silence he walked up to the dog, pointed his finger, gave it a circular motion and said, "Freckles, roll over!" and the dog rolled over.

The reunion was a joyous one and great were the theories and speculations on the adventures of Freckles for that year and one-half.

Unfortunately it was short-lived. About a week later the owner of the hens reported breathlessly that Freckles was in the chicken yard again, playing with his hens.

In the note that they gave to the Humane Society, the Greenfields said that Freckles was a nice, kind, gentle dog, especially with children—a good and faithful watch dog—but whoever they gave him to, be sure there are no chickens nearby!

J. G. McDaniel, M.D.

the association
the association
the association

NEW MEMBERS

Leigh, James H., Jr. Hall—Active—SU	194 Gold St. Gainesville, Ga. 30501
Parker, Gregg Dougherty—Active—ObG	401-B Madison Ave. Albany, Ga. 31707

SOCIETIES

Bibb County Medical Society held its annual formal banquet at the Idle Hour Country Club December 4 and named W. J. O'Shaughnessey as president, succeeding Jasper T. Hogan. Waddell Barnes was named honorary president.

New editor of **The Georgia Medical Society** bulletin is Frank E. Carlton of Savannah, author of a prize-winning story in *Salt Water Fisherman* and of many scientific papers.

At the November monthly meeting of the **Dougherty County Medical Society,** T. Gray Fountain was installed as president, Robert H. Groves as vice president, and William Mayher as secretary.

The December 11 annual meeting of the **Medical Association of Atlanta** saw the election of the following slate of officers: Edwin C. Evans, president; William D. Logan, president-elect; R. Carter Davis, Jr., secretary; L. Newton Turk, III, treasurer; David Dalrymple, junior board member; Earl W. Hathcock, Jr., William E. Huger, Jr. and F. William Dowda, senior board members; Keith Quarterman, northern district trustee; Thomas Tidmore, eastern district; Louis Felder, central district; C. R. Moorehead, western district; B. F. Voljavec, southern district trustee; Louis S. Riccardia, Judicial Council.

The Society's annual award, the Aven Cup, presented to the physician making the most outstanding contributions in the field of community service, was to be awarded January 19 at the annual President's Reception and party.

New president of the **Richmond County Medical Society** is J. Kenneth McDonald, practicing psychiatrist from Augusta, who succeeds Luther M. Thomas. John M. Martin is serving as president-elect, John Phinizy as vice president and Jimpsey B. Johnson as secretary-treasurer.

The **Second District Society** met December 8 in Tifton with Professional Standards Review Organizations and physicians assistants being the topics for the session.

PERSONALS

First District

Guyton residents honored **Charles T. Brown,** family physician, for a half-century of service to the area in ceremonies at Effingham County Hospital December 10.

Macelyn Anders, Statesboro family physician, has been presented a citation in plaque form for his participation in the American Medical Association's Project U.S.A. program. Dr. Anders served in Haynesville, Alabama for a period of time as part of the project.

Second District

Albany's **O. Grey Rawls,** general surgeon, has been elected to serve on the seven-member Phoebe Putney Hospital Authority. Selection was made by the Dougherty County Commissioners in October.

F. Morris Davis, Tifton, has been elected to active membership in the American Academy of Family Physicians.

Third District

J. C. Serrato, Jr., Columbus orthopedic surgeon, has been made a corresponding member of the Mexican Orthopedic Society of Monterrey, Nuevo Leon, Mexico.

Fourth District

The Decatur Exchange Club's "Golden Deed Award" was given to **John Rufus Evans,** family physician of Stone Mountain, at a November meeting. Dr. Evans is DeKalb Doctor of the Year, former director of the county's health department and former chairman of the DeKalb Hospital Authority.

Fifth District

H. Harlan Stone, Atlanta, co-authored an article, "Penetrating Wounds of the Abdominal Aorta" which appeared in the December 1973 issue of the *Southern Medical Journal.*

Seventh District

New MAG members **Raymond Young** and **Parke Avery** have joined the staff of Floyd Hospital in Rome. Dr. Young received his M.D. degree from the Medical College of Virginia and is a member of the American College of Cardiology. Dr. Avery, graduate of the University of Virginia School of Medicine, is a member of the Academy of Ophthalmology and Otolaryngology.

Tenth District

William B. Strong, assistant professor of pediatric cardiology at The Medical College of Georgia, is one of the developers of an exhibit which won the Gold Award for the Outstanding Teaching Exhibit at the American Academy of Pediatrics meeting in Chicago recently.

DEATHS

Frank Bird

Founder and operator of the Bird Hospital in Lake Park, Frank Bird, died November 28 at his home at the age of 84. Dr. Bird was a captain in the U.S. Army medical corps during World War I and was head of the medical unit of the Georgia State Guard during World War II.

Haywood N. Hill, Sr.

Atlanta cardiologist Haywood Hill, Sr., died December 1. Dr. Hill was clinical professor of medicine at Emory University and had served as chief of the department of internal medicine and on the board of governors at St. Joseph's Infirmary.

Dr. Hill was the author of many medical and religious articles, was former president of the Georgia Heart Association and Fifth District Medical Society, member of many professional organizations and an elder at Trinity Presbyterian Church.

A graduate of Davidson College in North Carolina and the Medical College of Virginia, Dr. Hill served in New Guinea and the Philippines during World War II. He had practiced in Atlanta since 1949 and was a partner in the Lowance Clinic.

Survivors include his widow, the former Susan Evans; daughter, Elizabeth Evans Hill of Hartford, Conn.; sons, William Edwin Hill of Atlanta and Dr. Haywood N. Hill, Jr. of Fort Rucker, Ala.; three brothers and one sister.

M. N. McCall, Jr.

M. N. McCall, Jr., who served Acworth for 32 years, died November 27 following a long illness.

Dr. McCall was a member of many civic and professional organizations including the Yarrab Temple in Atlanta.

Survivors include his widow, Mary Bolton McCall; daughters, Mrs. Bollan Camp of Dallas and Claire McCall of Atlanta; sons, Moses N. McCall, III of Lithia Springs, Hebert A. M. McCall of Stafford, Virginia, Russell W. McCall of Atlanta and Murl B. McCall of Acworth; one sister and two brothers.

Charles Marion Pugh

Lumpkin physician for more than 20 years, Charles Marion Pugh died November 27 in Stewart-Webster Hospital in Richland after a long illness.

The Lumpkin native was graduated from the Medical College of Georgia after serving as a teacher and coach for a number of years. He interned at Georgia Baptist Hospital in Atlanta.

Survivors include his widow, Mrs. Ruth Parker Pugh; daughter, Mrs. James Dennard of Tucker, son, Charles Marion Pugh, Jr., student at the Medical College of Georgia; two brothers.

John H. Robbins

John H. Robbins (Capt., U.S.N.M.C., Retired), died December 14 in Athens following a long illness. Dr. Robbins served in the Navy during World War I and II and retired in 1950.

He was associated with the University of Georgia Health Services, then worked with interns of two Athens hospitals before becoming house physician at the Heritage Convalescent Center in 1964.

Dr. Robbins is survived by his widow, Mrs. Grace Costa Robbins.

James Bartley Wilbanks

Forty-nine year old James Bartley Wilbanks of Clarkesville died November 11 of cancer. The Rabun County native served three years in the U.S. Army during World War II and then entered Emory University. Dr. Wilbanks was associated with the Georgia Department of Public Health for eight years before entering the Medical College of Georgia.

After internship and a practice in Hiawassee, Dr. Wilbanks came to Clarkesville, was associated with the Habersham Medical Group and joined the staff of Habersham County Hospital. He was the first physician to serve on the county hospital authority.

Dr. Wilbanks' survivors include his widow, Mrs. Joyce Tatum Wilbanks; daughter, Mrs. Arlton Cole of Norcross; son, Keith Wilbanks of Clarkesville; mother, Mrs. Frances Taylor of Clarkesville; three brothers and one sister.

Course on Diabetes Available at Emory

Physicians and other health professionals are being trained in best available methods of treatment and diagnosis of diabetic patients in a new program of the Emory University School of Medicine at Grady Memorial Hospital.

The Georgia Department of Human Resources is supporting the program with a recent one-year grant of $50,000. Training is conducted by Dr. John K. Davidson, Emory professor of medicine and director, Diabetes Unit; Mrs. Maria Alogna, nurse, and Mrs. Mary Goldsmith, dietitian.

Physicians may attend a 10-day course with instruction one day per week for 10 weeks. Available bimonthly to nurses and dietitians is a five-day course in a consecutive five-day program.

Participants are given in-depth instruction in a clinical setting and have an opportunity to observe the Grady Hospital Diabetes Day Care Center team functioning in the management and education of the diabetic patient, Dr. Davidson said.

The program is training an average of 15 physicians and 10 allied health professionals per month.

The Month in Washington

Two more major national health insurance proposals have been thrown into the Congressional hopper, bringing the total to eight with at least two more waiting in the wings, including that of the Administration.

Chairman Harley O. Staggers (D-W.Va.) of the House Commerce Committee has introduced his own national health insurance proposal (NHI), saying hearings will be held on his bill in the coming year.

The second new NHI proposal came from Senate Republican leader Hugh Scott (R-Pa.) and Charles Percy (R-Ill.).

Staggers' National Comprehensive Health Benefits Act of 1973 would provide comprehensive health care benefits and complete protection against the costs of catastrophic illness to all. It would be financed by a combination of contributions from employers, the federal government and individuals, scaled to income. The federal funds are for health insurance and catastrophic illness benefits for the poor and near-poor.

The introduction came shortly before hearings on NHI by the Commerce Subcommittee on Public Health and Environment.

It is the first major NHI proposal to be referred to the Interstate and Foreign Commerce Committee rather than the Committee on Ways and Means, Staggers noted, adding that it is the first NHI proposal by a chairman of a major committee in the House.

Major features of the proposal, as described by Staggers:

- a strong role for state governments in the development and administration of the program;
- incentives for the creation and use of Health Maintenance Organizations;
- a six-year transitional period for orderly development;
- the use of existing private health insurance carriers for administration of the insurance provisions;
- and the fact that the program builds on, rather than federalizing, the existing health care system.

The bill provides that newly created State Health Commissions (SHC's) would be responsible for the actual administration of much of the program, including standard setting and quality control, assisting in the development of Health Maintenance Organizations (HMO's), and administration of some of the insurance provisions. Existing private health insurance carriers would be used to underwrite most of the legislation's insurance benefits. The development and use of HMO's would be encouraged through additional direct developmental assistance and through a 10 per cent federal subsidy of HMO premiums.

Within two years of enactment, all aged, low income and unemployed individuals and families, would be

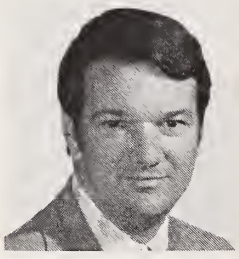
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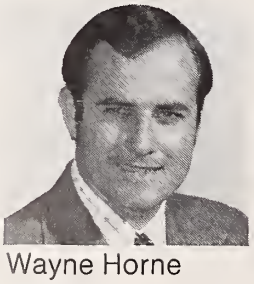
Jim Andrews



Steve Eades



Doug Hall



Wayne Horne



Bill Young

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These men bring you ...

provided coverage for basic health services. Within four years of enactment, all individuals and families would be provided coverage for basic health services and the costs of catastrophic illness. Within seven years of enactment, all individuals and families would be provided coverage for comprehensive health care benefits and the costs of catastrophic illness.

Senator Scott said his two-part "Health Rights Act" would provide for in-patient protection for all persons suffering major illness, and would set up an out-patient health maintenance insurance plan. It would replace both the medicare and medicaid programs now in effect. Scott added that he believed his bill was "must legislation" for this session of Congress "because its goal is to serve every American at a critical time."

Under the Scott-Percy Health Rights Act, both the in-patient and out-patient plans would be administered by insurance carriers or other public or private agencies on a regional basis, under contract with the newly created Office of Health Care within the Department of Health, Education and Welfare.

The in-patient, "major illness" protection differs from traditional catastrophic plans by covering all costs above each family's health cost ceiling, which is determined by a formula taking into account both family income and family size. Money for the plan would be financed in part through the present health insurance portion of Social Security payroll taxes and in part through general revenues.

The out-patient plan would be financed in part through family premium payments which would be supplemented in whole or part with federal payments for low-income families. Employers could arrange to finance all or part of their employees' premiums.

The Act would also establish a two-year, Presidentially appointed "Health Delivery Committee" to study the current and long-range needs for medical personnel and facilities. It would make recommendations to the President and Congress.

Food Supplements

The American Medical Association has asked the Congress to reject proposed legislation that would restrict the Food and Drug Administration's authority over food supplements.

In testimony before the House Commerce Subcommittee on Health and Environment, C. E. Butterworth, Jr., M.D., chairman of the AMA's Council on Foods and Nutrition, said the FDA's actions "are based upon sound scientific evidence and are clearly in the public interest."

Under new FDA regulations, U. S. government recommended daily allowances (RDA's) have been established that permit the inclusion of 19 essential vitamins and/or minerals in products to be marketed as dietary supplements. "The RDA's are based on those formed by the National Academy of Sciences and reflect the most current scientific judgments on the subject," said Dr. Butterworth.

Ingredients with no recognized nutritional value would be excluded from dietary supplements.

"There is no scientifically acceptable evidence to support the use of bioflavonoids, rutin, inositol and other

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similar ingredients," said the witness. "It is our opinion also that the quantities of vitamins included in mixtures for dietary supplementation should furnish daily an amount which approximately fulfills but does not greatly exceed the recommended dietary allowances," Dr. Butterworth testified. Inclusion of excessive amounts of fat-soluable vitamins A and D can be harmful, and "is scientifically unwarranted and potentially dangerous," he said.

Dr. Butterworth said: "It clearly would not be in the public interest to enact legislation virtually eliminating the authority of the Secretary (HEW) to control the kinds and amounts of ingredients in the dietary supplements and other foods for dietary use. The current regulations promote safety, and provide full information to consumers about such products, and this information will enable them to make decisions based on scientifically acquired data."

Retirement for Self-Employed

Legislation liberalizing tax treatment of retirement savings by the self-employed seems to be moving closer to congressional enactment in the next Session.

The House Ways and Means Committee has tentatively approved the Senate provision allowing self-employed people such as lawyers, dentists and physicians to claim tax deductions on $7,500 a year, or 15 per cent of income, for sums placed in qualified pension plans. This compares with the previous Keogh limit of $2,500 or 10 per cent of income.

The threat of a strict limitation on pension tax deferments in corporations, including professional service corporations, appears to have diminished. The Ways and Means Committee in general accepted the principle in the Senate bill of a $75,000 annual limit on retirement benefit plans (so-called defined benefit plans) and on others (defined contribution plans which included profit-sharing, money purchase, etc.) of a retirement benefit not to exceed 100 per cent of the high three years of average compensation.

Ways and Means must still take a final vote and also work out with the House Education and Labor committee an agreement on the form the overall legislation—a sweeping pension reform measure—will take when presented on the House floor. Defeated in Ways and Means was a move by labor, an arch enemy of the Keogh provision, to reduce the tax deferral to a maximum of $5,000 per year.

Emergency Medical Systems

President Nixon has signed into law a three-year, $185 million bill to help set up emergency medical units around the nation.

The bill authorizes grants and contracts for feasibility studies, planning, establishment, operation and expansion of emergency medical systems (EMS) as well as research and training. Rep. Tim Lee Carter, M.D., (R-Ky.) said in House debate it would assist communities throughout the nation to develop and improve their emergency medical services systems and "contribute directly to saving tens of thousands of lives each year."

President Nixon had criticized the bill in a veto earlier this year, contending that existing federal and state programs are adequate to handle the problem. The veto led to a major confrontation with Congress last September in which the Administration won when the House failed by a narrow margin to muster the required two-thirds vote.

The bill increases from 50 per cent to 75 per cent the federal share of grants for emergency programs and earmarks 20 per cent of grants for rural areas.

The Administration's prime objective to the earlier bill was an amendment ordering that all public health service hospitals be kept open. The EMS law does not contain this provision. However the PHS hospitals were kept alive by a rider to a military appropriations bill that was subsequently signed into law.

Emergency Radio Frequencies

The White House has said that it plans to designate enough radio frequencies for emergency medical service to serve the entire country.

Clay T. Whitehead, director of the White House's Office of Telecommunications Policy, says this will be a vital first step in giving American communities the kind of integrated emergency medical services they need to save thousands of lives a year among persons stricken by heart attacks and strokes or injured in accidents. Many such persons now die because they do not get adequate emergency care before they reach a hospital.

Estimates of the number of lives that could be saved each year if all regions of the country had adequate emergency care systems range from 60,000 to more than 100,000.

Mr. Whitehead noted that a few cities already had efficient systems including two-way communication between ambulance and hospital and radio equipment for sending vital data on the patient's condition from the scene of the emergency to doctors at a hospital. For most American communities, he said, such arrangements are still nothing more than science fiction.

Dr. Charles C. Edwards, assistant secretary for health in the Department of Health, Education and Welfare, said the department was putting a high priority on efforts to develop an efficient emergency medical system throughout the United States. How much of the effort should be Federal and how much locally initiated is under study, he said.

The Administration plan calls for allocating 38 radio frequencies for emergency medical use throughout the United States. Mr. Whitehead said 22 were already available, but on a much less standardized basis. Some of the others are now used by the Department of Defense and other Federal agencies. Still others are used for highway callboxes, ski patrols and the like. A few are not allocated.

Citation for Service

The American Medical Association has awarded a plaque to David Kindig, M.D. in recognition of his "outstanding and dedicated service in implementing the goals and objectives of the National Health Service Corps (NHSC)."

Dr. Kindig played a key part in launching the NHSC program of sending PHS physicians into physician-shortage areas where help is requested by the local and state medical societies. In receiving the award, the youthful physician said the cooperation of the AMA and of the nation's local and state medical societies has "been unique and made the program a success." ■

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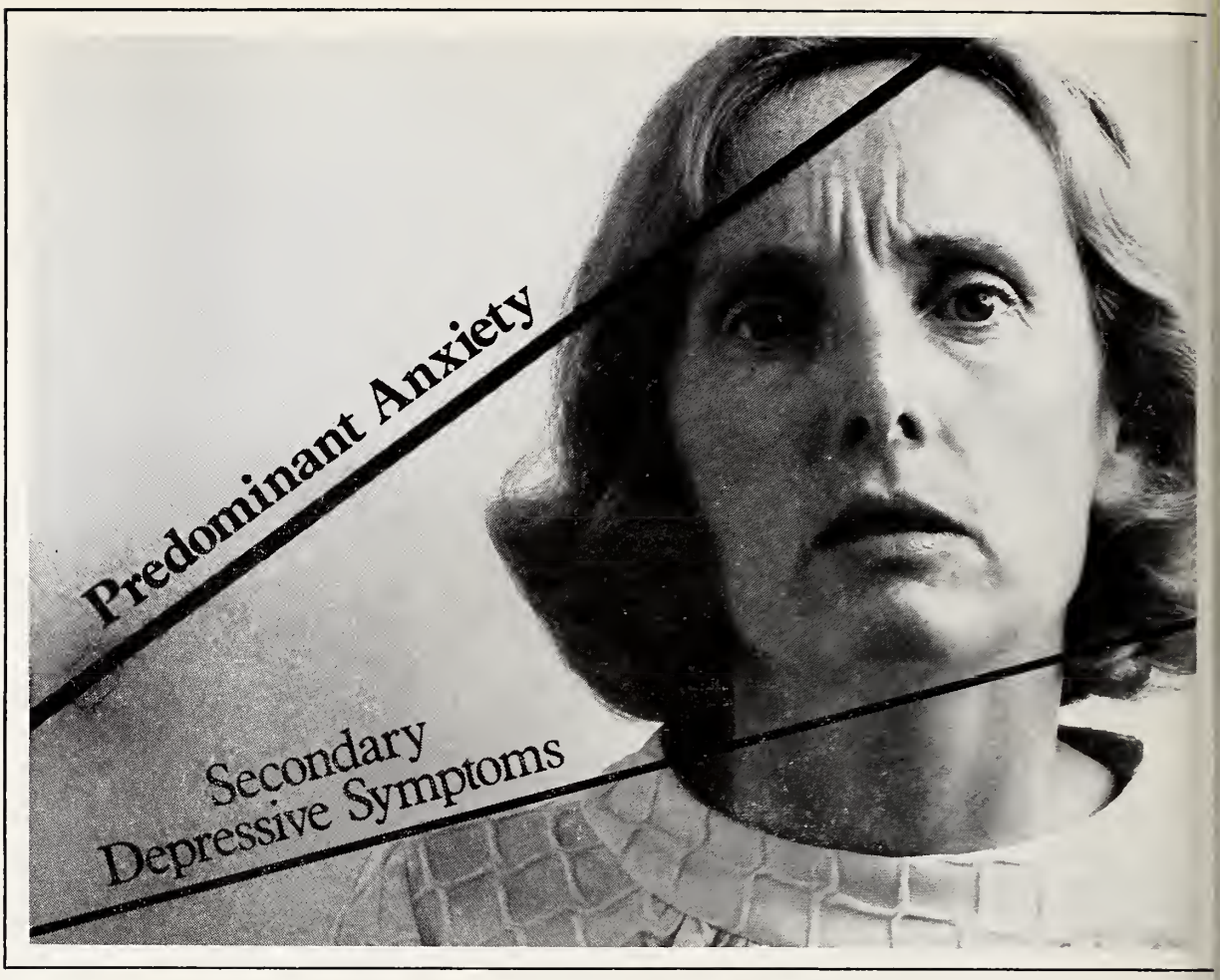
WINTER CRYPT

I describe the way that I feel?
the stream I was crossing
Had suddenly frozen,
ked my ankles in an icy grip,
ilizing that once-fluid force
And I with it...
d we have nothing to do
ut wait until the thaw.

Porter Halyburton/Hanoi 1969



The Story of One POW
PAGE 43



This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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THE COVER

The world's press greets newly-released POW Porter Halyburton. This happy day was four long years after Halyburton wrote "Winter Crypt" expressing his feelings toward prolonged captivity. Design by Bob Hamill, Atlanta.

Physician...

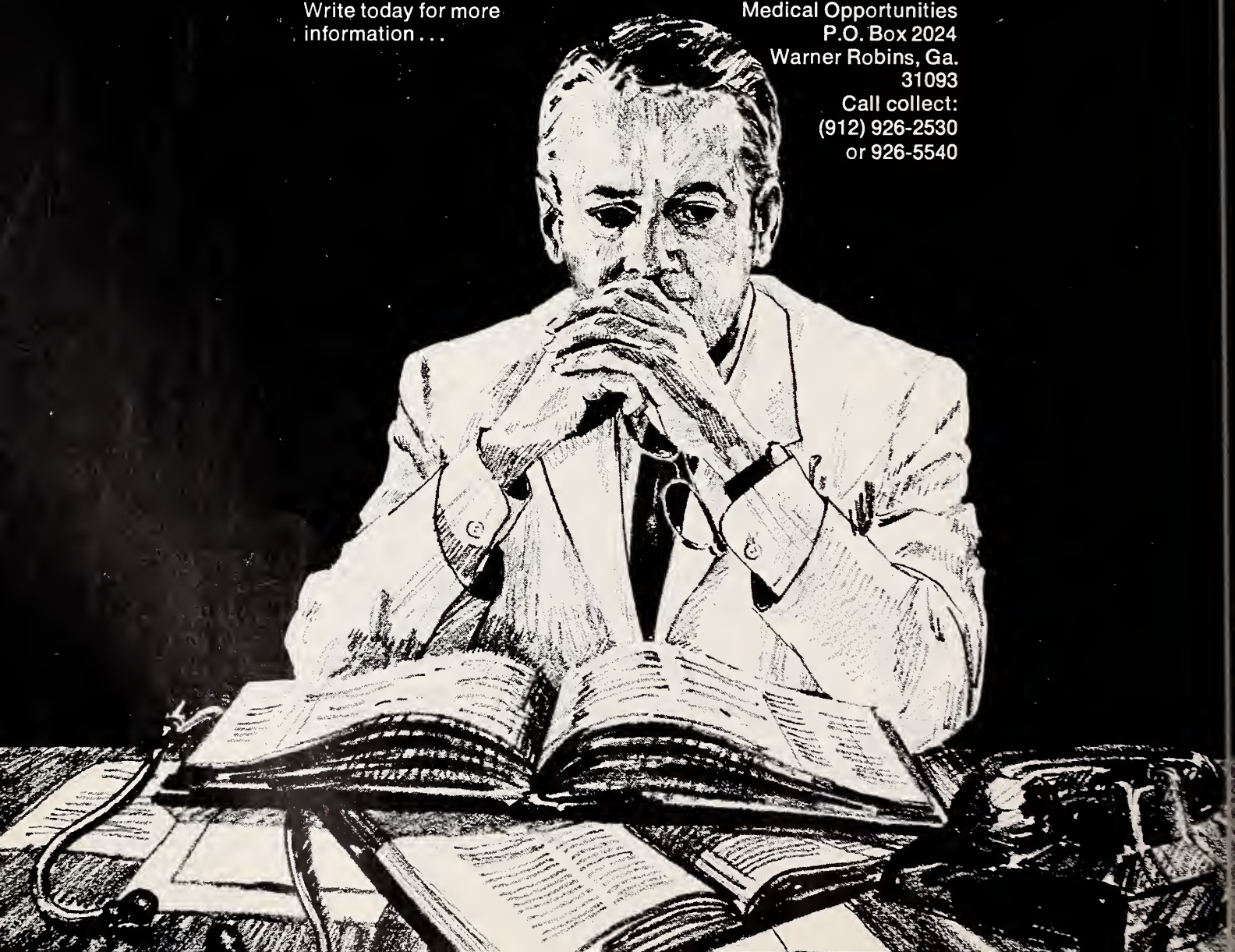
TAPER OFF TO A 40-HOUR WEEK IN THE AIR FORCE

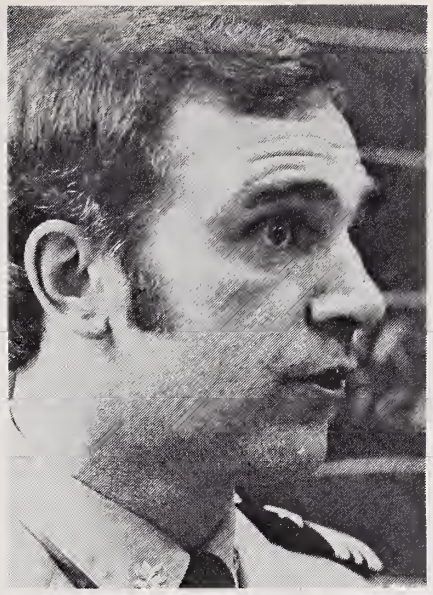
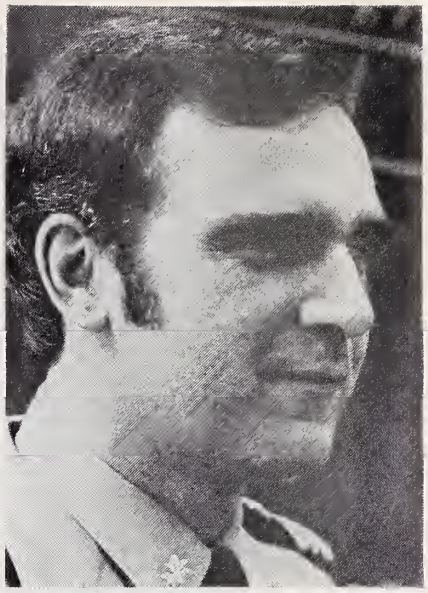
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Porter Halyburton, POW

One Man's Story of the Fight Against Pain, Boredom and Abuse

JMAG: When you were shot down in October 1965 you were declared KIA, killed in action, weren't you? Why was this, and how long was it before it was known and your wife was told that you were a prisoner of war?

Halyburton: I was declared KIA simply because nobody saw me get out of the airplane, saw me on the ground or anything like that, and the Vietnamese did not inform anybody that they had me. I was KIA until, I think it was the Swedish government finally extracted some information that I was there.

This was in the early part of 1967. It was around a year and a half or so. It was 1970 until we actually exchanged mail. I got the first letter from my wife almost five years, five years to the week, from the time I was shot down. She received my first one about that same time, too.

I can forgive them a lot of things, but that's one thing I could never. A post card saying, you know, we've got so-and-so—which is, incidently, part of the Geneva Convention that they are required to do that.

JMAG: What did they hope to gain by not saying whom they had captured?

Halyburton: I don't know, whether it was that they thought they would be freer to do with you what they wanted if they didn't have to account for you when the whole thing was over. In other words, they could kill you at any time there and nobody would know the difference. But I don't know. I know that a lot of the guys that, say, received a lot of publicity at the time they were shot down, their names would be released. And they were, by and large, the ones that would write home in the early days. But this is a small percentage. If you made it in the news when you were shot down, then chances are you're going to write.

JMAG: Did you receive letters in return?

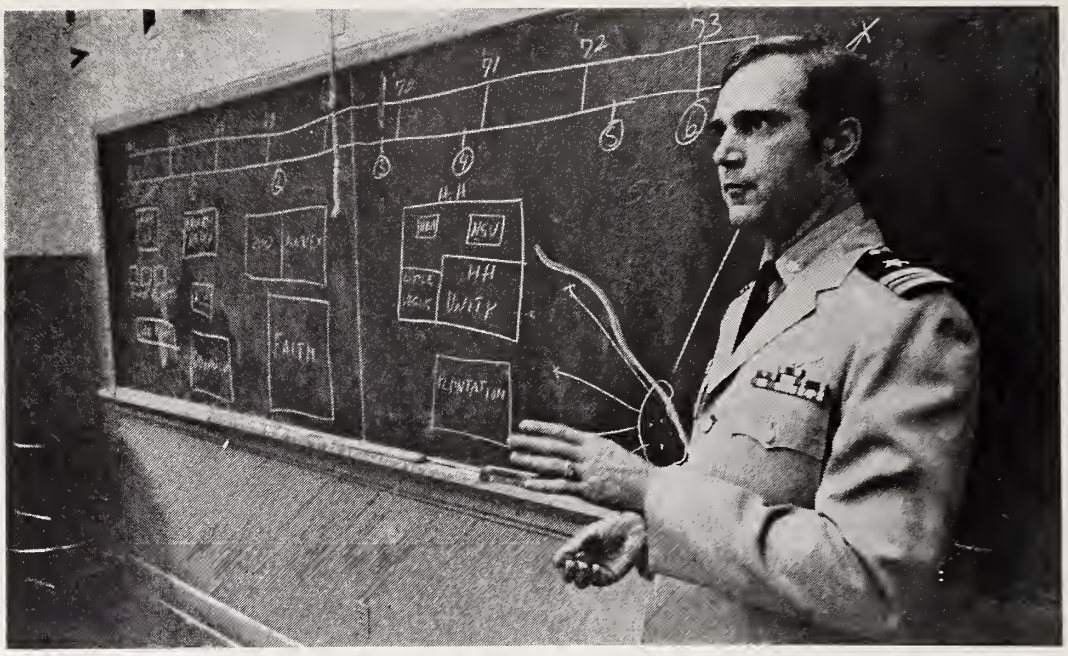
Halyburton: Yes, but back in those days if you received two or three letters a year you were doing real well. It wasn't until late '69 or actually early '70 before everybody started writing. Before they just picked out

PORTER A. HALYBURTON was born January 16, 1941 in Miami, Florida. He moved with his mother, once a nurse and woman's editor for the Charlotte Observer, *to Davidson, N.C. as a child and attended Sewanee Military Academy in Tennessee his last two years of high school. He was graduated from Davidson College in 1963 with a bachelor's degree in English and enlisted in the Naval Reserve. He and his wife Marty were married in 1963 and Halyburton was commissioned the following year. Their daughter Dabney was born in April 1965 just before he left for Vietnam as a radar intercept officer aboard the* USS Independence.

He was shot down October 17, 1965 in an Alpha strike, the biggest combined strike of the war to that point. His plane was hit on their way into the target, a bridge at the North Vietnamese steel complex at Thai Nygun.

The Halyburtons now live in Tucker and he is studying international politics and journalism at Georgia State University. He serves as a consultant in Navy ROTC at Georgia Institute of Technology. Much of his time since returning to the United States has been occupied with answering the thousands of letters written to welcome him home.

Photos courtesy Lt. Commander Richard A. Bennett, director of the Atlanta Branch, Navy Office of Information. The poems, "Winter Crypt" and "Metamorphosis" are copyrighted 1974 by Porter A. Halyburton.



Life at "Briar Patch" and the "Zoo"

Halyburton charts his time as a POW into seven sections. The beginning of a new time period could denote a change in location, for the POWs were moved frequently from one camp to another, or a change in general treatment, for the better or worse. These changes in treatment often were touched off by outside events, such as the bombing of an oil storage camp, a rescue attempt or the death of Ho Chi Minh. Not every prisoner experienced the same changes, but his case may be typical.

Alvarez was the first POW, shot down in 1964. Halyburton was number 40, captured October 17, 1965 after ejecting from his crippled F-4B Phantom Jet and a 20-minute "evasion" period. He was in-processed at the infamous "Hanoi Hilton" and taken to a newly-opened prison, the remains of an old French Film studio, called the "Zoo." He counts his first period from capture until the summer of 1966.

This first time span was characterized by isolation, poor food, neglect and widespread beatings and torture. Early in that time period, January 1966, the petroleum oil lubricant storage tanks were bombed in Hanoi and the Vietnamese got "very rough, mean and nasty after that." As a result he was moved to "a terrible camp out in the country called the 'Briar Patch'" which was another old French prison. Conditions were bad, the food was the worst it was to be, medical treatment was non-existent.

In January of 1967, Halyburton moved back from Briar Patch to the Zoo and found slightly improved medical treatment and food. By the spring of 1968 the Vietnamese had captured a couple of hundred POWs and were running out of room. They found they could keep them in isolation no longer, so first set up a controlled experiment with eight or 10 men in a room "and got them to a point where they would obey any order and do absolutely anything that they wanted them to do."

Though the treatment now was basically the same, having "eight other guys to talk to is great," Halyburton says and he begins the third period there.

These POWs stayed in eight-man rooms until the fall of 1969 when Ho Chi Minh died. The treatment changed again as the Vietnamese were re-evaluating their policies and were feeling the pressure of public opinion in the United States which called for better treatment.

In the summer of 1970 they were moved to a camp in the country that had been built especially for the American POWs, "The first kind of good deal that we had gotten," Halyburton says. They were grouped in compounds of 50 to 60 men, with four to six compounds in the camp. They were allowed to communicate freely with other prisoners and some compounds were given ping-pong tables and volleyball equipment.

Things changed over night as in November 1970 a rescue attempt from the outside was tried at a camp just 10 miles away. Immediately they were packed up and sent back to the Hanoi Hilton in rooms for 50 to 60 people with long concrete slabs for beds. This situation continued until early 1972 when other camps were opened up and treatment was improved again, books and education materials were handed out as the Vietnamese "thought the war was going to be over before too much longer and they were hoping to get propaganda by the soft sell method."

The last period of time he designates is from December 1972, when the United States began bombing Hanoi. This time "was just gravy again, doors open, the medic was around every day, three times a day asking if anybody has a headache . . . we're having turkey . . . I played my first game of basketball and volleyball or anything like that in 1973."

He was released February 12, 1973.

individuals to write letters, and now they would call the whole room out or stick letter forms in there.

JMAG: At the time you were captured, were you injured at all?

Halyburton: Nothing except minor stuff, bruises and scratches. But I didn't break any bones or anything like that. I had a back condition, which I still have, which didn't show up until some time in 1968. Now, how much of that had to do with the ejection, I don't know. The modern ejection seat gives you a pretty good kick in the pants. Depending on the air speed and things like that; it gives you 12 to 20 G's, instantaneous G's. A lot of compression fractures of the spine and things like this occurred, however, they haven't found any compression fractures or anything like that in my back.

JMAG: Did you have any physical activity or have to do labor for the Vietnamese while you were a prisoner, that might have aggravated this condition?

Halyburton: Well, yes. We had to do a bunch of things. One was sweeping the streets and sidewalks of the camp. And their idea of a broom doesn't have a handle on it, it's just a whisk broom made out of rice stalk. So in order to use it, you have to bend over at a 90 degree angle. After doing that a couple of hours, your back is really under a strain.

Shortly after I moved out there to Briar Patch, when things got really rough, I was beaten in the back several times severely with rifle butts. These were all in the lower and middle back area. My back started giving me trouble after that.

JMAG: When you were beaten, was this because of your resistance, or because they felt like doing it to let you know they were around?

Halyburton: Well, I think most of these with the rifle butts were kind of "off the record." They were just individual actions by guards. They were not supposed to do that. It was just a general program of harassment and mistreatment. In the morning they would ring a gong, and it was still dark outside. And they would come and get you up with a stick—just poke you until you got out of bed. And if you weren't up just the instant the gong rang, the guards would come around and throw rocks and stuff through the windows.

Then, as soon as it got light, they came around and handcuffed your hands behind your back. You stayed that way all the rest of the day until it got dark at night. And they would take the handcuffs off and you would eat again. Two meals, both of them in the dark, one early in the morning, then late at night.

JMAG: Was there some reason for feeding you in the dark?

Halyburton: Well, they explained that there was great danger of the camp being bombed and this was for our own safety, so that we could be evacuated immediately from the camp. That's why we had to stay in handcuffs.

JMAG: Were these prisons the cages we have heard about?

Halyburton: No, it was a cell. This was a prison with bars at the windows and big heavy doors, stone walls about that thick. . . . The bed was wooden pallets about six feet long, three feet wide. . . . So the room was maybe six or seven feet wide and maybe 12 feet long.

At this period of time out at the Briar Patch they got real hot on discouraging us from communicating and the punishment for communicating was to spend 60 days in a hole in the ground, which was supposedly an air raid shelter, a hole in the ground, and could fill up with water.

Mosquitoes would breed in there and there were an incredible amount of bugs and toads and all this kind of stuff, rats. We had kind of stucco walls and rats would just play on the walls all night. There was one guy that was chained to his bed and he was there for quite a while. Of course the skin around there would die and peel off, and the rat would come up and chew that off at night. He'd throw his cup at him and stuff like that. It was pretty bad.

But the punishment was to spend 60 days handcuffed in the hole. Now this wouldn't be torture type handcuffs unless the guard was mad at you. No mosquito net or blanket or anything like that, window closed. You couldn't even talk to your roommate, if you had one. You never went outside your room, got out of your cuffs only to eat.

JMAG: Did you ever become more or less immune to the mosquitoes?

Halyburton: Well, you learn to live with them. Malaria was not particularly a problem. A very small percentage of the people had malaria. We would see the malaria mosquitoes, the anopheles, they were the ones that were standing on their heads. You would see them, they would warn us about them, and of course we tried to keep away from them. We had a mosquito net that they would take away from you occasionally for punishment.

JMAG: Was there a rainy season during the year, did your conditions vary with the weather?

Halyburton: Right, the spring was the worst as far as mosquitoes. There was very little weather that we found agreeable. About two or three months in the fall and the spring . . . but in the spring months with the good weather came incredible amounts of flies and mosquitoes and so on. September and October, perhaps into November, would be your relatively pleasant months. In the winter months it would be bitter cold and either extremely humid or extremely dry. And in the summer it would be, again, very hot and extremely humid or extremely dry.

JMAG: With what kind of clothing were you provided?

Halyburton: The clothes were kind of the black pajama variety. Sometimes they weren't black, sometimes they were kind of red striped and sometimes they were a kind of green or tan, but they were all relatively thin cotton clothes that had a draw string, no pockets or anything like that. The first winter there was probably the coldest. There was one blanket and the blankets were the same thing the soldiers had—they were relatively thin cotton blankets and they are not very warm compared to a wool blanket. One of them is not going to hack it.

JMAG: Did you have any shoes?

Halyburton: No, the first winter I had no shoes, or socks or anything like that. What they issued finally were . . . it looked like shower clogs, but they were made out of rubber tires. "Zaps" we called them. They make them in Mexico, too. They are not very comfortable, but at least they keep your feet off the cold floor or you can go outside. We also had a sweat shirt which

was pretty similar to American sweat shirts, that same type of material. As time went on they finally gave us a pair of socks, so that was about it.

JMAG: Let's change the subject a bit and talk about the psychological problems you faced and how you handled them. Were these problems different for everyone?

Halyburton: Well, I don't know. I hesitate to say what other people's psychological problems were. There were people there that definitely lost their grip on reality. . . . But my own amateur opinion is that if people had emotional or psychological problems when they went in there, then they were more likely to surface under strain. So that maybe the first time a guy is tortured or beaten around or so forth, this would produce an adverse reaction in him.

I would say yes, there are factors there that are going to cause psychological problems in almost anybody. Isolation is one of them, just being by yourself for a long, long period of time. Isolation is different than being in solitary confinement, according to my definition. Solitary confinement means you're living by yourself but can talk to other people, you can communicate with other people. Isolation means that you're completely isolated from other people, from outside inputs. And of course you have nobody else to talk to except yourself and you're not getting any inputs or anything like that. Your thinking can wander quite a bit during those periods of time.

" . . . If people had emotional or psychological problems when they went in there, then they were more likely to surface under strain."

JMAG: Today we are always surrounded by other people and noise from radio and television. Being alone is considered a luxury.

Halyburton: That's right. And I think being able to be alone for certain periods of time is an advantage. But you can't be alone all the time. Boredom can be incredible if you let it. But if you have, what I would say, a healthy attitude about it, you are going to learn what you can from any situation you are in. Like, if your room is full of ants, then all of a sudden you develop an intense interest in ants, and you learn everything you can about them, just watching them for hours and hours a day. Spiders or mosquitoes or rats, whatever you've got in your room, that's what you watch. That's the way I tried to approach it, anyway. But if you just sit there kind of inactive then I think isolation can hurt.

JMAG: I understand you wrote poetry during this time. Do you think that a lot of creativity may have surfaced as a result of having to create your own pleasurable situations?

Halyburton: I think so, that's probably the case. Writing poetry was not new to me, I had been doing that for a while, but I think a good many other creative type things would come from that. Necessity is the mother of invention still applies there. When you are in a situation where you have nothing and you must make something in order to have something, then, of course, you're going to find a way to do it.

We made just an incredible number of things out of things you wouldn't expect . . . like bread dough. We made things out of mud and clay, cigarette ashes. There are all kinds of things you can do with cigarette ashes. Probably the most valuable thing was a toothpaste tube, lead toothpaste tube. You can write with it, you can make a little ashtray with it. . . . I think a lot of people occupied their time with kind of arts and crafts kinds of things which were strictly for pleasure or to some specific end.

JMAG: I understand you spent some time making "books" and in language studies.

Halyburton: I think that the study of languages was of great help and it consumed a lot of time. It was an educational thing that we could do without any textbooks, just learning words and phrases and so on from the people that knew them. And as time went by we gained more information and we needed to write it all down. So we began to look for ways to write it down. Of course, the Vietnamese never allowed us to have pens and paper and this kind of stuff until the very last. So we made things. If you take a cigarette and unfold the paper, you wind up with a piece of paper about that long and that wide. . . . We used a match stick, a strip of bamboo or something dipped in ink that we would make out of cigarette ashes and sugar, or pigfat if we couldn't get any sugar. . . . The diarrhea pills were little brown things and if you would crumble it up and dip it in water it makes a beautiful kind of red ink. We called them "ink pills." People never took them, you were not allowed to take one of those pills!

We wrote on toilet paper, which is kind of like a commercial paper towel, the brown, coarse kind. Except if you made it about twice as coarse, and there were little grains of sand and stuff like that in it. We would glue two or more sheets of this together with rice glue and it made a fairly substantial, fairly smooth writing surface. We actually had hard bound books in the end when they were leaving us alone.

JMAG: I have seen an example of the writing. A piece of paper this small must have had a thousand words on it or more.

Halyburton: When you don't have much paper and

METAMORPHOSIS

Trembling and silent before the threshold,
We stand on the eve of our Resurrection.
Hardly daring to believe that at last
The valve may crack and we may seep
Into the tip of an infinitely expanding horn,
To be belched into that crowded carnival,
An old song.

She stands before me, silent, across the wide river;
Her smile seen dimly through the damp fog.
Watching through my peephole, I can only
Whisper her name—Freedom. . . .
And I, within my hardened shell,
Await Rebirth.

Hanoi
February 1, 1973

a lot of this stuff we were hiding from them. My entire library I could put into a small box, but there would be maybe a dozen pieces of paper. I would have every piece of poetry that I had memorized, every word that we had in German, Spanish and French . . . written in, we called it "miniaturized," kind of a microfilm idea. . . . We could get every Spanish word, rule, and declension on a piece of paper this big. And you fold it up real small and put it in a little bitty plastic bag or something like that and you could put it in your mouth or wear it in your shorts if they inspected.

JMAG: Did you actually set up class schedules to keep yourselves busy, determine a certain time for a certain activity?

Halyburton: Oh, yes, I'd say from this period on, from the spring of '68 when we moved into the eight-man rooms we did it. Any room I was ever in we had an education schedule, program, an education officer who was responsible for that. Every day there would be lectures or classes. There might be an entertainment officer and he would arrange for people to tell stories or maybe put on a skit or any number of things. Panel shows, people told movies. Toward the end when we finally had playing cards . . . we made them out of toilet paper and things like that for quite a long time . . . finally they gave us cards that we got in our packages and so forth.

JMAG: When you were in these eight-man rooms, did everyone have a specific responsibility like the education officer and medical officer, or would just two or three?

Halyburton: Well, almost everybody was some kind of officer except maybe one or two guys who were the "men," but this gave everybody responsibility to do something.

JMAG: What were you?

Halyburton: Well, I was the executive officer in one room, and from then on after I moved out of that situation with some more senior people, I was education officer most all the time until we got in the situation when I became communications officer.

JMAG: What did that entail?

Halyburton: Depending on the situation that meant that you would spend from one to three hours a day transmitting messages from one place to another by various means.

We basically had two main methods of communications. One was the tap code, which was the alphabetical matrix which you could translate or you could just move your foot like that, and if somebody sitting out there was looking at the door and could see my foot, he could "hear" me say "Hi" by watching my foot. . . . You could translate the tap code into anything—you could make a motion or you could make a sound. But after we got more organized and things loosened up, you could see by getting way up into a window and could see into another window, if the guy got up over there. Mostly we communicated through one of these six by six inch ventilation holes, and you could fit your hand into that little space there and you could communicate.

That was the fast way and it is just a hand alphabet similar to the mute code. Of course, you can abbreviate things like "R" for "are," and "U" for "you." One time I had to spell "Czechoslovakia," and you know if the word is coming across and you're not familiar with it, then you can read every letter and still not grasp the meaning. So I spelled Czechoslovakia by going like that (a "check" mark) and then spelled the rest of the word.

JMAG: How would you go about teaching somebody that you couldn't see and you couldn't speak to?

Halyburton: There was one particular instance where it took 56 days to teach these two guys the code. We tried everything—leaving them notes, we tried tapping the Morse code, we tried, as we walked past their rooms, to whisper a couple of quick words, and so on. We just couldn't get through to them. However, when we would start tapping on the wall, occasionally we would hear them come over to the wall and maybe tap

" . . . If your room is full of ants, then all of a sudden you develop an intense interest in ants, and you learn everything you can about them . . . "

back. . . . So one day they came over and we were tapping on the wall using the code, just hoping they would figure out what was going on, and the guy responded.

So what we finally did, we started with one tap, and then two and then three and went all the way to 26. Then we would spell out "hi" (which would be eight taps and then nine taps). So eventually he gets the idea that first you are giving him instructions and then sending him a message. And then finally, he gets the idea. You can just see him over there counting as you go "a (one), b (two), c (three). . . ." And he gives a giant bang on the wall—the light bulb came on!

Then it is a slow process of using that same method to explain to him how to use the tap code.

JMAG: Was there a great deal of time spent on efforts concerning how to get out of there? Was escape a really viable factor in your existence?

Halyburton: Well, escape is something that you're bound to try to do, if you can, and yes, we always had plans, you know, if the opportunity arose. It was always more like a study, a committee assigned to study the possibilities. I would say that if you took the percentage of time devoted to that every day it would be quite small because most people were of the opinion that your percentages were so low, that unless something unusual happened you weren't really going to try.

I was only in about two rooms that I thought I couldn't get out of. I could get out of almost any room I was in. Consequently getting out of the camp was a relatively simple thing. But then where are you? You're right in the middle of a country full of 17 million yellow-skinned, five-foot-four, black-haired people. You're standing six feet tall, white-skinned, no shoes, no water, nothing.

JMAG: If others tried to escape, did it change the type of treatment you received?

Halyburton: Yes, it did. During this period here, '68 to late '69 there was an escape attempt in our camp, and it changed our treatment a great deal. For example, after that we weren't even allowed to walk around the room, no physical exercise whatsoever, in the idea that they were going to break us down physically and maybe we wouldn't be in physical shape to escape. Just incredibly intense and frequent inspections

of the room and they would take anything that they found that you weren't supposed to have.

JMAG: Did you feel that they overreacted a lot?

Halyburton: The Vietnamese? Yes, they sure overreacted a lot on that. They do not see things, of course, the way we do. They just went berserk after this particular attempt—because it was planned. And some others, unsuccessful escape attempts, they didn't do much at all, because they were kind of escapes of opportunity—a guy saw a chance to make it and he made it.

JMAG: Do you think in some ways they were afraid of you, they thought that you were cleverer than they were?

Halyburton: Oh, yes. They would never admit that we were, but they were afraid of us. I think that was one thing that motivated a lot of what they did. They overreacted, they were super cautious about so many things. They were so afraid of us, of what we could do, because they saw what we could do.

JMAG: Do you think that you and others in your situation consciously knew what was needed to make the best of the circumstances, that you must exercise, eat whatever food was available, keep yourself healthy?

Halyburton: I think that most people did. There wasn't any doubt that I did. I realized right off the bat that it was a survival situation and you have to stay mentally, physically, spiritually alert and active, maintain a healthy overall existence. And you're only getting a limited amount of food, so you couldn't afford to be picky about it. If they bring something in there and it looks like you can eat it, eat it! It may not taste good, it may look even worse. Many times you couldn't afford to look at your food or you would never eat it. And this period of time we were eating in the dark, it was probably a good deal. Even though the cockroaches would get a lot of it if you didn't keep one hand on the food. I've had a spoonful of rice almost in my mouth and the cockroach leaps off the spoon and back into my plate.

JMAG: Did you work at trying to instill this kind of attitude into new prisoners, that to be successful at surviving they must put some effort into being inventive and creative, make the best of things?

Halyburton: In listening to a lot of comments from guys as they were reflecting back on the times they got there or shortly after they got there, they would be amazed at what we had done, at the morale we had . . . the stuff that we have made, you know, the incredible communications network. We laugh and joke about a lot of things that other people cry about. . . . After they had been there a while they were the same way, so I think it kind of rubbed off.

There were some periods when I would say the group was not as creative, and you could see it. The Vietnamese would be more effective in what they were trying to do, if they were trying to get everybody to bow, or something like this. I got more beatings over that one thing than any other. It was just bowing, and if you make a game out of it, even though it is a serious game, then it makes it a lot easier psychologically.

JMAG: I understand you came up with a philosophy as a result of the beatings, a way of dealing with them.

Halyburton: We're talking about psychological things, I think the worst psychological blow that I had there was the realization that I wasn't as tough as I thought I was, as a result of people telling me that I could be that tough and that everybody else was. I had been roughed up and hurt and so on in the past up there, but it wasn't for anything particularly important. However, when it got down to the nitty gritty and they wanted something important, they wanted me to sign something that was important—this is what you are there for, this is when you give it all you've got.

And that's what I did, that's what most people did. Well, the first time that this situation came up I said, "Well, this is it," and I was willing to die rather than do that. And so I gave it everything I had. Quite a few hours later I had reached the point where I could no longer hack it. I couldn't stand any more pain. There was no way I could kill myself or knock myself unconscious or anything like that. There was very little left.

Well, at this point they just kind of kicked you in the hands a couple more times and went away and laughed at you. A few hours later they come back and you're really a vegetable. I had reached my breaking point. I would have done practically anything they wanted. . . . I believe this is going to be true with almost anybody. Give me a pair of handcuffs and a couple of other things and I can make almost anybody do anything that I want if I had no holds barred and no time limit.

Fortunately for me they didn't ask me to do anything until the next morning which was several hours later. And in that period of time I recovered some of my will to resist. . . . I wasn't recovered enough that I was going to say, "No, I won't write," but what I was going to write for them was not going to be what they wanted.

So my general philosophy was that the name of the game is not to see if you can get yourself killed or permanently injured, the name of the game is to give them just as little as possible, that's why you resist in the first place. My philosophy after that was that if they want something important they are going to have to torture you to get it and you will take a significant amount of torture to prevent them, because there is always a chance they will give up. But once you determine that they are not going to give up . . . then why not say you're going to do it for them at a point that is short of your true breaking point . . . so that you still have some means to resist. You can outwit them. . . . That later became part of wing policy . . . you will accept torture but only to the degree that you can retain your mental facilities.

"We laugh and joke about a lot of things other people cry about . . ."

JMAG: It appears that among other things you seem to have learned just what your limits are, your capabilities, learned more about yourself.

Halyburton: There is no question about that. I think you learn a lot about your own limits in a good many areas. I had probably never done more than 38 push-ups in pre-flight, and I was in pretty good shape in pre-flight. In Hanoi I did 64 on a much crummier diet. But it was just a question of I was going to see how many

pushups I could do. There were some guys there that could do 100 pushups in a row. A very good friend of mine did 2,500 pushups—they weren't continuous, he was resting, but he never took his hands off the floor or touched his knees. I did 7,000 deep knee bends. You know, it takes all day to do 7,000 deep knee bends! There were guys who did 4,000 and 5,000 sit ups. I never did that because you always wound up with an exposed tail bone, it would literally rub a hole in your hind end.

JMAG: Let's get into the medical aspects of your life as a POW. Those who were injured when they were captured, what kind of initial care did they ceive before they were put into a camp?

Halyburton: Well, I would say it would depend on the individual case. If the guy was shot down, say a couple of hundred miles from Hanoi and he's eventually going to go to Hanoi, they may put some kind of splint on a broken bone or a cast. They may not set the bone, they may immobilize it in some way. Or again, they may just throw the guy in the back of a truck and take him 200 miles to Hanoi. And he's bouncing off the deck of the truck that high when they hit potholes, and he's a vegetable when he gets there.

JMAG: There were no amputees that came back, were there?

Halyburton: I don't know why that was. I'm sure they could have had some, they could have cut off a guy's leg and cauterized it and the guy would have been in fairly good shape. But for some reason they chose not to have any amputees. I know it is a lot of work and this guy is going to be handicapped and he couldn't do things for himself that they maybe would have to do for him.

I know that they let people die that were badly injured, unless they had some other reason not to. I know of two guys that were left to die and they were incredibly banged up, you know—two broken legs and a smashed shoulder, all banged up and full of shrapnel and things like this. And these guys were left to die, in a ditch or just thrown in a room somewhere with nothing. . . . This was not uncommon. The other two men that I was speaking of just turned out to be extremely tough, exceptional people and refused to die. Finally the Vietnamese said, well, maybe they will live and they gave them a blanket and started giving them some food. Never did much for them. I know one guy they did take a big piece of shrapnel out of his leg, they just cut it open with a machete, reached in there and pulled it out. But they never set his broken leg or removed any of the rest of the shrapnel. He just did it all himself.

JMAG: Were the other POWs able to help them?

Halyburton: Oh, the guys that were really in bad shape, most of the time would have somebody in there to help them. I think this was the case with my first roommate, an Air Force major, and he had a dislocated shoulder and a broken ankle. . . . They eventually operated and I'm sure he almost died as a consequence of this operation several times afterwards.

JMAG: What kinds of injuries were sustained as a result of the torturing?

Halyburton: The Vietnamese would generally reset broken bones if they occurred like this. They were generally careful to try not to do anything that would cause permanent damage like a scar. . . . Now they did use ropes. . . . When they hit you with something, it was generally a rubber strap or something like this that might cause you injury, it might break the skin and so on, but it wouldn't leave a big ugly scar there. And they would hit us in the face with padlocks, shoes and all kinds of things like that. But never a haymaker type blow that would break your jaw or smash your nose all over your face. You learn to roll with the punches.

There weren't too many broken bones. There were chipped teeth and black eyes and lots of broken ear drums. They used an open hand a lot, instead of a fist, and if they catch you across the face with an open hand they could break your ear drum, which is very painful.

JMAG: What was the caliber of medical personnel that you were allowed to come in contact with?

Halyburton: Low, very low. Most of the people that we came in contact with was the guy that normally calls sick call, or if you complained about something, the guy they sent around would be a medic.

Now, he's about as highly trained as a boy scout and

"The body, we found, is a very amazing, very tough, forgiving piece of gear that if you just left things alone it would take care of itself in many cases."

he'll give a shot. He may not know how to give it right, but he'll give a shot. They are sloppy, dirty, they have very little concept of hygiene. They do things for show a lot of the time. These guys wear white smocks and little white caps and yet they've got their rubber tire shoes with their bare toes sticking out covered with dirt. Their hands are dirty, their finger nails are just black. They don't wash their hands or anything, but the white smock symbolizes someone in the medical profession and that is very highly regarded. Someone of stature. So they make a show of it. They may make a show of boiling a needle, but if they drop it on the floor they pick it up and stick it on the hypodermic and give the shot. It's too much trouble to boil it again. They already did that once, why do it again?

JMAG: Did you ever try to reset broken bones for each other?

Halyburton: Well, generally by the time they would get a roommate, they would either be in a cast or the bones would have started to grow together. It was better just to let things alone. And the body, we found, is a very amazing, very tough, forgiving piece of gear that if you just left things alone it would take care of itself in many cases. Another guy I knew had a completely broken, shattered shoulder. He can do 100 pushups. Everything is still all broken in there. . . . He just left it alone but he had to constantly work on it, force it to do something, that kind of therapy.

JMAG: Other than injuries when you were captured or tortured, what were the other problems with which you had to contend? The description of the average POW shows so much weight loss, sores all over his body, etc.

Halyburton: Oh, yes, it was true, especially during these first periods when your diet is very poor, you're trying to adjust to the food. Not only don't you have very much food, but you have dysentery or acute diar-

rhea, and you're just not processing the foods that you do have, you're just putting it in the bucket over there. So I estimate I lost about 40 pounds or so initially. . . . During the summer heat rash was a problem.

JMAG: It sounds like the kinds of things that made you just plain uncomfortable were a problem.

Halyburton: Oh, yes. Heat rash and boils and all kinds of fungus type infections. People had weird things they had never had before.

One of the worst periods of time that I spent there was when we moved back to the Zoo here in early 1967 . . . and this room happened to be in such a position that it got the sun on two walls all day. . . . The temperature outside every day was well over 100, and easily inside this room I would say the average temperature was 120 degrees. . . . Sweat is just continually pouring off you, and any movement or activity would cause a "seige," an incredible itching sensation. It generally starts on your extremities, legs or arms, and if you did happen to take a bath sometime in here, the first time you put water on it it would start one of these things, a seige. It's just kind of a burning, itching, stinging thing that just makes you want to claw at your skin. It really lasts only a minute or so, but if it lasted an hour, you'd go crazy. And of course there was nothing on your body that wasn't covered with heat rash. Even the palms of your hands would have little white pockets of pus.

And they were only giving us a cup of water twice a day, so you were dehydrated. So when you are coping with things like that things get serious. . . . We learned to live with things. You live with 10 or 12 boils on your body at the same time. You're going to try to do everything that you can, like force it to come to a head. When they bring our drinking water it is generally hot. They boiled it and gave it to us hot. If you take a cup of hot water and put it up against this thing, it would come to a head sooner.

JMAG: What other little tricks did you learn about medical treatment?

Halyburton: Well, toothpaste. We did get this toothpaste that was pretty bad. . . . A guy would catch an ear infection, you name it, we'd try toothpaste on it.

JMAG: When you were released finally and taken to Clark Air Force Base, how did you feel physically and what kinds of medical attention were given immediately?

Halyburton: I felt that I was in pretty good shape. I had been doing an awful lot of physical training, which is what we had been doing for quite a while, whatever your diet would let you. I could squat down and do 50 pushups and situps and deep knee bends. I probably couldn't run very far. I didn't have that kind of wind or stamina, but I could do a lot of calisthenics. I felt good. My weight by this time was up to 158, 159 pounds which was only about 10 pounds under my normal weight. I found that I could only sleep about three or four hours a night, and that lasted for a month or so. I'd wake up real early in the morning and I had to get up.

They corrected immediate things at Clark. We went through a fairly complete physical, but they were looking more for things that needed immediate attention. We didn't get worm treatment to get rid of parasites, we could worry about that later.

JMAG: Were you put on a special diet to overcome deficiencies in what you had been receiving?

Halyburton: No, just normal food. There were some people that were put on special diets that had had stomach problems. Some people with ulcers or something like that.

JMAG: How did you cope with such a long period of time as a POW, not knowing when, if ever, you would be released?

Halyburton: I don't think you ever believed that you were never going to go home. It was just that if you said "I don't think we're going to go home any time soon" and you accept that. . . . In other words, you were prepared for a long stretch of time. The Vietnamese always told us the war may last for five, 10, 15, 20 years and you may be here that whole time. Well, you know, if you fight that and think, "No, I'm not, I'm going home tomorrow," and tomorrow comes and you don't go home then it's a series of disappointments. But if you say, "O.K., I'm going to be here 10 years. I'll settle back and try to enjoy it." And then tomorrow comes and they set you free—then it is a great surprise. It's not a letdown, it's not a psychological letdown. . . .



Halyburton's wife, Marty, did not know for a year and a half that he was a POW instead of a war casualty. She was active in programs to free the prisoners. Daughter Dabney was an infant when Halyburton left for Vietnam.

I always had a lot of faith that we were going to go home, that we weren't going to be there any 10, 15 years even though we were pressing on 10 and I never thought that would happen.

JMAG: We hear about a lot of adjustment problems for POWs, but you appear to be a clear example of how easily and how well some have been able to make these adjustments.

Halyburton: Well, I don't think you're going to find anybody that has no problems in adjusting. They may be minor, they may not be apparent, but I don't think you would find anybody that has had no problems.

However, I think there are many very happy cases where problems have been easily overcome and worked out and so on. If you're gone, you're separated from your wife for seven years, there is no way that you can, everything can be just the same. She's going to change, you're going to change and you're going to have to readjust to those changes. But if you remain somewhat flexible and understanding, and she does the same thing, and you're still in love, in the end it's all going to work out and you will readjust which fortunately has been the case with me.

JMAG: How do you relate to a child that you have never had the experience of talking to before?

Halyburton: That adjustment there has been incredibly easy. I'm blessed in that our daughter is very flexible. Marty hauled her around with her everywhere she went, and she just learned to accept situations, and she accepted me and I accepted her and that's about the way it was. That's been just a no sweat problem at all.

JMAG: I understand you are very much concerned with the efforts to help the MIAs.

Halyburton: Well, I think that even though these people may or may not be alive, the family at least deserves a sure knowledge of whether they are or not. Now if you could go over there and identify teeth or anything, dog tags or anything like that and come back and say, "Look, we found the remains of your husband or son, that yes, he is dead." That I think is going to make it a lot easier on those families. . . . The very idea that the North Vietnamese won't even offer an accounting—like the guys that we knew were for a fact there and alive. Maybe even the Vietnamese released pictures of them and so forth. Yet the Vietnamese claim to have no knowledge whatsoever of this guy, never even being there, much less being killed.

JMAG: What happens if another Vietnam occurs and they call Lt. Commander Halyburton?

Halyburton: Well, I'll probably go if they call, but the prospects are very unlikely that they ever would. I think the only way I would go back into combat is if we had a world war and they were calling up everything they had. . . . But I couldn't stay in the Navy and take my paycheck and say that if we had another war and they wanted me to go, that I wouldn't go. If you were opposed to war, if you were unwilling to go to war, the military is not the place to be. So if I was going to stay in the military, I would accept that particular responsibility. Not that I want to go back, but when you're working for somebody and the time comes to do what it's all about, then you do it or get out prior to that time. ■

Highlights of Council

January 12-13, 1974

Condition of Membership-Bylaws Change: Approved submission of language to House of Delegates, allowing reinstatement of delinquent member upon approval of county medical society and payment of back dues owed unless excused by Executive Committee.

MAG Delegation to AMA: Authorized delegation to select alternates using a process of rotation unless special circumstances dictate otherwise.

Building and Land: Voted to expend $5,000 for option on land adjoining MAG Headquarters and asked for continued consideration of new site for MAG Headquarters.

AMA Board of Trustees: Endorsed candidacy of John P. Heard, M.D., Decatur and voted to appropriate $3,500 for his campaign.

Phase IV: Received report on Phase IV's effect on physicians—allowing a four per cent increase in gross income and requiring posting of sign indicating fee schedule available for inspection.

PSRO: Approved expenditure of $60,000 for activities related to MAG's effort to repeal the PSRO law.

Scientific Meeting of Annual Session: Authorized delay of institution of MAG Scientific Meeting from 1974 to 1975 in hopes of obtaining greater specialty society cooperation and involvement.

Georgia Medical Care Foundation: Extended current term of office of Board of Directors to the March meeting of Council.

EMCRO: Accepted the resignation of F. William Dowda, M.D., as principal investigator and appointed the MAG secretary, Earnest C. Atkins, M.D., as his replacement.

Legislation: Voted to support mandatory newborn coverage in any insurance policy that includes dependent coverage; and support for comprehensive maternal health services. Directed the Legislative Committee to develop definition of practice of medicine which would include practice of clinical and anatomical pathology for inclusion in the Medical Practice Act.

HMO: Received a report from legal counsel on the federal HMO law. Approved continued opposition to the HMO bill in the Georgia legislature.

Next meeting: March 9-10, 1974, Macon Hilton Hotel, Macon, Ga.

Physicians are urged to use this testing facility in appropriate cases.

Sickle Cell Testing in the State Laboratories

EVA E. BLAKE, M.T. (A.S.C.P.), M.S., *Atlanta**

In October 1972 the Division of Physical Health, Georgia Department of Human Resources, began a screening program for sickle cell anemia to support two Georgia laws. One requires that applicants for a marriage license be offered a test for sickle cell anemia while the other requires that all infants of the susceptible ethnic origin be tested for sickle cell anemia. Most of the test samples are submitted by health departments and most of the patients are 3 to 15 years of age. Since over 11,000 patients have been tested and numerous interesting hemoglobinopathies have been detected, a sharing of these test results seems appropriate. When an abnormality is detected testing of family members is encouraged. For this reason the percentages reported here cannot be used as an index of prevalence.

Materials and Methods

The primary screening test is alkaline electrophoresis using supplies from Helena Laboratories as modified by Schmidt and Brosious.[9] Controls consisting of a mixture of hemoglobins (normal, Hb A; fetal, Hb F; sickle, Hb S; and Hb A_2) are applied with each electrophoretic run. Patient samples that show one hemoglobin band that migrates as Hb A are reported as normal.

The presence of Hb S is confirmed by a solubility test which the Georgia Retardation Center Laboratory developed. This test based on a recent publication[8] substitutes saponin as the lytic agent in the proportion of 1 g per 100 ml of the working solution. When an alkaline electrophoretic pattern shows two bands that migrate as Hb A and Hb S and the solubility test is positive the patient is reported as having sickle cell trait (AS).

A third procedure was added in June 1973. All abnormal samples except those showing sickle cell trait or Hb A with an elevation of Hb F are subjected to acid electrophoresis, pH 6.3, using the citrate agar system supplied by Helena Laboratories. When there is not an elevation of fetal hemoglobin the results of the three tests may confirm these conditions: C trait (AC), C disease (CC), and SC disease (SC). Acid electrophoresis differentiates Hb C from those variants with a similar alkaline electrophoretic mobility.[7, 9, 10]

Those variants with an alkaline mobility similar to Hb S but with a negative solubility test are retested by acid electrophoresis to substantiate that the variant is not Hb S. These rare findings are reported as Hb D with the recommendation that reference testing be done.

When alkaline electrophoresis shows that fetal hemoglobin is elevated this finding is reported. For all other conditions the electrophoretic mobility at each pH is described on the test report. A complete hematological examination is needed for the definitive identification of sickle cell anemia, or an interaction between Hb S and thalassemia, or for any other hemoglobinopathy.

Genetics and Hemoglobin Biochemistry Review

After six months of age about 97 percent of the hemoglobin found in the blood is Hb A; Hb F and Hb A_2 make up the balance.[3, 9, 10] Each of these types is composed of two pairs of globin chains which are bent and folded to form a specific shape. and each chain holds a heme group.[3, 4, 5, 9, 10] Hb A has two alpha chains composed of 141 amino acid residues and two beta chains composed of 146 amino acid residues. Hb F has a pair of alpha chains and the two remaining chains called gamma differ from the beta chain by 39 amino acid substitutions. Hb A_2 has two alpha chains while the two remaining chains called delta differ from the beta chain by 10 amino acid residues.[3, 4, 9, 10]

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A globin chain is a series of amino acids that have been joined together with covalent bonds by eliminating the elements of water. These bonds are called peptide bonds.[5]

The abnormal hemoglobins are usually transmitted through a recessive mode of inheritance. An individual who has one normal gene and one abnormal gene will be a carrier (heterozygote) of the disorder with only limited expression of the trait. But those persons with two abnormal genes (homozygote) will have the disease entity. Parents who are both carriers of the disorders have with each pregnancy a 25 percent chance for an affected child, a 25 percent chance for a normal child and a 50 percent chance of having a child who is a carrier. Children of parents where one is normal and one is the trait have a 50 percent chance of being carriers.[10]

The primary structure of a protein, the sequence of amino acids in a globin chain, is under genetic control.[3, 4, 5, 9, 10] This order of amino acids depends upon the sequence of nucleotides in deoxyribonucleic acid (DNA). The particular segment of DNA which regulates the synthesis of polypeptide chain is called a cistron or gene.[5] Each triplet of nucleotides in DNA codes for a specific triplet of nucleotides in messenger ribonucleic acid (mRNA).[5, 10]

The defect that induces a hemoglobinopathy can be described as either structural or quantitative. The former is an alteration of the amino acid sequence in a globin chain which occurs when there is a substitution or deletion of a nucleotide in DNA or mRNA. The subsequent alteration of the genetic code causes a corresponding change in the primary structure of the globin chain.[3, 4, 5, 10] A quantitative defect is an alteration in the rate of synthesis of a globin chain. This makes the assumption that there is a gene loci for rate synthesis of polypeptide chains as appears to be the case for bacteria. A mutation at a regulator gene loci would explain the suppression of synthesis of a globin chain found in thalassemia and the continued synthesis of gamma chains found in hereditary persistence of fetal hemoglobin (HPFH).[3, 10]

The clinical manifestations of the abnormal hemoglobin molecule depend upon both the functional aspects of the substituted amino acid and its location in the globin chain. Methemoglobin forms *in vivo* by the variant which results when tyrosine is substituted for one of the histidyl groups involved in oxygen transport.[3, 4, 10] The unstable hemoglobins which vary in clinical significance result from the the substitution of a polar amino acid for a non polar amino acid in that area of the globin chain which has contact with the heme group.[3, 4]

Results

Table 1 gives the test results through August 1973 basing the hemoglobin type on the alkaline electrophoretic pattern. As explained earlier until June 1973 definitive testing was limited to the normal pattern (AA) and sickle cell trait. Since adding citrate agar electrophoresis 164 samples have been checked confirming 120 cases of C trait, five cases of homozygous C disease and eight cases of SC disease. None of these 133 patients had an elevation of Hb F as might be expected were there an interaction with beta thalassemia or HPFH. The Hemoglobinopathy Standardization Laboratory, Center for Disease Control (CDC), has done reference testing on 69 additional patients. Stress must be placed on the importance of a complete hematological examination and family studies in arriving at a diagnosis, especially when the electrophoretic pattern suggests sickle cell anemia or when there is an elevation of Hb F or Hb A_2.

Hb S accounts for the majority of abnormal findings. The defect is structural and occurs in the beta chain; the sixth amino acid from the N terminal end, glutamic acid, has been replaced by valine.[3, 4, 5, 8, 9, 10] Globin chain electrophoresis is required to identify those variants with an alkaline mobility similar to Hb S but with a negative solubility test. Table 1 shows 25 cases that were reported as Hb D trait (AD). Five of the six cases that were referred to CDC were reported as probably being the alpha chain variant Hb G Philadelphia and the remaining case was reported as probably being the beta chain variant Hb D (see Table 1). While Hb G Philadelphia has no clinical significance[3, 10] the condition resulting from the presence of the genes for Hb S and Hb D (SD disease) produces anemia.[1, 4, 7, 10]

The second most frequently found abnormality is Hb C. Again the sixth position of the beta chain is involved; lysine replaces glutamic acid[3, 4, 6, 9, 10] This substitution apparently causes an intracellular attraction, because intracellular crystals can be formed by subjecting Hb C containing erythrocytes to gradual osmotic stress.[6] Reference testing is planned for a young patient who appeared to have homozygous C disease. He has C hemoglobin plus a second variant with an alkaline mobility similar to Hb C, probably Hb E or Hb O Arab.[7, 9, 10] Hb E is found in Asians.[3, 4, 10] The interaction of Hb O Arab with Hb S has been found in Jamaica and the condition described is more severe than SC disease.[7]

Fast Moving Hemoglobin

One of the first hemoglobinopathies that was detected is a "fast moving" hemoglobin. This general

name describes the alkaline electrophoretic mobility of a number of benign variants; the amino acid substitution produces a molecule with an anodal attraction which is greater than Hb A.[10] Reference testing is necessary to differentiate the benign fast hemoglobins from Hb Bart's and Hb H which are found in certain thalassemic conditions.[3, 4, 9, 10]

Another early finding in our screening program was an adult with a large amount of fetal hemoglobin in addition to Hb A. Reference testing done at CDC gave the laboratory diagnosis of HPFH. This genetically controlled condition must be correctly identified. An elevation of fetal hemoglobin is found in many different anemias including sickle cell disease, homozygous C disease and thalassemia.[3, 4, 9, 10] In these conditions the fetal hemoglobin is not evenly distributed among the erythrocytes. Two populations of cells exist because some red blood cells contain Hb F while others do not. An important characteristic of HPFH is that the fetal hemoglobin is evenly distributed and all the red blood cells contain some fetal hemoglobin. A special method which elutes all the hemoglobin from the erythrocytes except the Hb F can distinguish HPFH from those other conditions in which fetal hemoglobin is elevated.[3, 4, 9, 10]

Retesting was requested on the one patient (Table 1) with only fetal hemoglobin present. The sample was collected when the patient was six months of age and this infant may have HPFH.

More Than Two Bands

The electrophoretic pattern of seven individuals had more than two hemoglobin bands. Of the several conditions that provide an explanation the most likely is a recent blood transfusion. Also at least four bands are theoretically possible in an individual who is a double heterozygote with an alpha chain defect and a beta chain defect. Cellulose acetate electrophoresis should reveal Hb A, the alpha chain variant, the beta chain variant, and a combination molecule containing both defective chains.[4] Several bands of hemoglobin have been described in the electrophoretic pattern, pH 9.0, of the heterozygote for Hb Richmond, because this beta chain variant forms asymmetric hybrids.[2] As noted in Table 1 reference testing at CDC has identified one such patient.

Table 1 shows two cases were detected where reference testing provided the laboratory diagnosis of an interaction between Hb S and beta thalassemia. The alkaline electrophoretic pattern of these individuals show the Hb S band staining more intensely than the Hb A band. Since beta thalassemia is a quantitative defect less Hb A is present in the patient's erythrocytes.[3, 4, 10] Findings such as this are reported as "SA" and reference testing is recommended. The one patient from Table 1 with beta thalassemia minor is the offspring of one of the sickle cell thalassemia patients.

Electrophoresis is not a satisfactory screening test for thalassemia though Ab A_2 is often elevated in beta thalassemia minor.[3, 4, 7, 9, 10] There is no simple laboratory test for the detection of these syndromes. Thalassemia is a condition in which a person has an abnormal production of hemoglobin causing his blood cells to be delivered to the circulation in inadequate numbers and inadequately filled with the proper hemoglobin and, in addition, the cell survival time is shortened.[3, 4, 10]

In closing, the importance of reference testing and a complete hematological examination should be

TABLE 1

HEMOGLOBINOPATHY TEST RESULTS, OCTOBER 1972 THROUGH AUGUST 1973
GEORGIA DEPARTMENT OF HUMAN RESOURCES

Hb[1]	AA	AS	AC	AD	Fast	SS	AA↑F	SC	≧ 3 Bands	SA	CC	F	Total
Total	9508	1133	314	25	5	31	183	19	7	5	9	1	11,240
Percent ...	84.60	10.08	2.79	0.22	0.04	0.28	1.63	0.17	0.06	0.04	0.08	< 0.01	

[1] Hemoglobin type based on the electrophoretic mobility, cellulose acetate membrane, pH 8.4:

AA, normal; AS, two bands migrating as Hbs S and A and positive solubility test; AC, two bands migrating as Hbs A and C and a negative solubility test; AD, two bands migrating as Hbs A and S and a negative solubility test; fast, one band migrating as Hb A and second band migrating with greater anodal attraction than Hb A; SS, Hb S band and positive solubility test; AA↑F, two bands migrating as Hbs A and F; SC, two bands migrating as Hbs S and C and positive solubility test; ≧ 3 bands, 3 or more bands appearing to represent equal hemoglobin concentrations: SA, predominate band migrating as Hb S, faint band migrating as Hb A, positive solubility test; CC, one band migrating as Hb C and negative solubility test; F, one band migrating as fetal hemoglobin.

Reference testing performed by Hemoglobinopathy Standardization Laboratory, Center for Disease Control (as of 9-18-73):

AC, 50; CC, 3; SC, 3; alpha chain defect, probably G Philadelphia trait, 5; beta chain defect, probably D trait, 1; sickle cell anemia, 4; sickle cell beta thalassemia, 2; beta thalassemia minor, 1; hereditary persistence of fetal hemoglobin, 1; A-Richmond hybrid, 1.

emphasized. Often Hb F is present and several interpretations could be made from an abnormal electrophoretic pattern. This is especially true in those cases where the patient may be either a homozygote for sickle cell anemia or C disease or have an interaction between either of these abnormal variants and thalassemia or HPFH. All of these conditions are inherited, and the true diagnosis may depend upon determining the hemoglobin types of the parents and siblings.

The services of this laboratory are available to physicians in private practice for their patients who are either suspected of having a hemoglobinopathy or who should be tested as required by one of the two Georgia laws. Outfits and instructions are obtainable by writing:

Central Supply
Old Farmers Market
Building 12
1050 Murphy Avenue
Atlanta, Georgia 30310

Since submitting the manuscript in September 1973 additional testing has resolved the interpretation of two cases with three or more hemoglobin bands (See Table 1). One patient has SC disease and at the time of the first testing she had just received a blood transfusion. Reference testing done by the Hemoglobinopathy Standardization Laboratory, Center for Disease Control, confirms that one patient suspected of being a double heterozygote does have the trait conditions for the alpha chain variant, Hb G Philadelphia, and the beta chain variant, Hb C.

The author wishes to thank the staff of the Biochemistry Section, Georgia Department of Human Resources, her supervisors, and Dr. Henry Palmer, DeKalb County Health Department, for suggestions and assistance in preparing the manuscript. ■

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Highlights of Executive Committee

January 12, 1974

Appointments: Education Committee—Ernest C. Fokes, M.D., Decatur; Public Health Committee—William S. Davis, M.D., Atlanta, and Charlotte Neuberg, M.D., Macon; HMO Study Committee—David A. Wells, M.D., Dalton, J. Winston Huff, Atlanta, Harrison L. Rogers, M.D., Atlanta, as chairman, Carson B. Burgstiner, M.D., Savannah, Luther M. Thomas, M.D., Augusta, F. G. Eldridge, M.D., Valdosta.

PSRO: Recommended to Council adoption of a massive campaign to repeal PSRO at a cost of $60,000. Reappointed PSRO Committee with authorization for dividing into subcommittees.

EMCRO: Approved submission of grant proposals, 1) Nursing Home Medical Records; 2) Nursing Home Review Systems; 3) Development and Evaluation of Outcomes. Appointed Earnest C. Atkins, M.D. as principal investigator. Accepted the resignation of F. William Dowda, M.D., as EMCRO principal investigator and voted their commendation.

AMA Board of Trustees: Endorsed candidacy of John P. Heard, M.D., Decatur, for AMA Board of Trustees.

A brief history of midwifery is outlined and patient acceptance is discussed.

The Role of a Nurse Midwife

W. NEWTON LONG, M.D., *Atlanta**

I DON'T KNOW THE EGYPTIAN word for midwife, but I do know that there were such around 1500 B.C. (*Exodus,* Chapter 1, Verses 15-19). Indeed, prior to the Nineteenth Century, the physician's role in obstetrics was minimal, intervening only in the most difficult deliveries and most perilous intercurrent problems; and, as might be expected, most of the babies and many mothers died. It is understandable that women were terrified when a physician was called in because this presupposed that the situation was already just about hopeless. At a Paris hospital in the 1870's, where half the patients were assigned to the Midwifery Service and the other half to Medical Service, women pleaded to be placed on the former because the chances for survival were so much better.

If I had been assigned this topic 20 years ago, my task would have been easier. The role of a nurse midwife at that time was none. Oh, there were nurse midwives in the United States and had been since the 1930's; for example, the Frontier Nursing Service in Kentucky and Maternity Center in New York City. Nurse midwifery had a great reputation in Europe. In fact, in France, nurse midwives were known as "sages femmes." But, by and large, American midwifery grew up on the frontier and was practiced by the untrained, if not the inexperienced, and was by the end of World War I relegated to the care of the indigent rural woman. As a consequence, in the United States prior to 1953, "midwife" was a bad word conjuring up the image of an elderly, illiterate, incompetent woman who made a good or poor living off of women for whom no other care was affordable or available. But, before we leave the granny midwife, we should note that her track record was pretty good and maternal and perinatal mortality would have been appalling without her.

The nurse midwives produced in the United States before 1953 generally worked as nursing supervisors on obstetric units; taught maternal and child health in schools of nursing; and, in a few areas (home deliveries in New York City, on Indian reservations, and in the mountains of Kentucky) did clinical obstetrics.

With the baby boom following World War II, it became statistically obvious that the American obstetrician was about to have a big problem. Babies born between 1945 and 1950 would start having babies of their own in 1965 to 1975. Generalists, or general practitioners, would be doing fewer deliveries every year. Fewer medical school graduates would be selecting obstetrics as a specialty (more would be entering geriatrics and psychiatry). It is true that about 15 new medical schools would open, but the obstetrics clientele would increase faster than we could produce physicians to serve them.

One of the leaders of American obstetrics, Dr. Nicholson J. Eastman, foresaw this problem and set about in the late 1940's to establish high quality training for nurses who wished to become proficient in the art and science of obstetrics. What to call the product . . . that was the question. Obstetrologist? Obstetric Associate? Obstetricist? Obstetric Assistant? The name decided upon came about for two reasons. The first was that most of the early graduates were headed for the mission field, where the British certification system was used. Here competence was attested to as "midwifery," the generally used British word for obstetrics. The second reason was that initial funding was from a mission board, which also favored "nurse midwife."

Schools opened in Baltimore, Md.; New Haven, Conn.; New York and Santa Fe, N. M. with some dif-

* Professor of gynecology and obstetrics for Emory University School of Medicine, 80 Butler Street, S.E., Atlanta, Georgia 30303. Dr. Long delivered this paper at the Ninth Annual Rural Health Conference, August 30, 1973 in the Macon Hilton Hotel.

ferences of emphasis. Generally, what have evolved have been graduates of certificate programs and master's programs (M.P.H. and M.S.N.). Prerequisite is an R.N. certification. Certificate programs require one year of didactic and practical obstetrics and neonatal pediatrics. Master's programs require two years, including more sophisticated basic science and further education courses. An internship is recommended, and the American College of Nurse Midwifery has established a certification program involving academic review and oral and written examinations.

As of now, there are 700 certified nurse midwives in the United States. When this is compared with the membership of the American College of Obstetricians and Gynecologists—15,254—it can be seen that only the merest beginning has been made. This works out, as you can see, to about one nurse midwife per 20 gynecologists/obstetricians. No assurance exists that we can ever produce enough nurse midwives to be a major factor in American obstetrics. Indeed, there are those who feel that salvation lies in training paramedics for isolated specific jobs—nurse clinicians for prenatal care; physician associates for help in labor and delivery; and family planning clinicians. We acknowledge that such make great contributions, that they can be trained quickly to do a specific job. We regret the fragmentation of patient care and the lack of perspective that the assembly line practitioner must often have.

Having somewhat cursorily traced the development of this health discipline from shaky beginnings to a shaky present, I shall try to define by example the various roles that the nurse midwife plays and can play in this country. It needs to be said at the outset that, with the exception of the Frontier Nursing Service in Kentucky, no nurse midwife functions in this country in any but hospital delivery. I swore off home deliveries 25 years ago and do not expect anybody else to be compelled to practice obstetrics in a manner that I am unwilling to do.

Far and away, the greatest number of practicing nurse midwives are employed by county and municipal health departments and municipal or publicly supported hospitals. Such is the employment of nurse midwives in the New York City Health Department rotating between prenatal and postpartum outpatient clinics and labor and delivery units of municipal hospitals. In Baltimore, nurse midwives work in the input terminus of the Maternal and Infant Care Project and in delivery of normal parturients at Baltimore City Hospital. In such a role, how is nurse midwifery failing and succeeding?

(1) The nurse midwife is a threat to some third and fourth year medical students and to some rotating interns. As a general rule, by the end of a year of association, the intern or assistant resident recognizes that these extra pairs of skilled hands help to free him from the crushing load of normal deliveries, allowing him more time to perfect his skill in gynecology and complicated obstetrics.

(2) Medical students in their sophomore year are oriented to labor and delivery by nurse midwives, who demonstrate such technical points as surgical scrub, gowning and gloving and draping, how to evaluate uterine contractions, how to give emotional support in labor. This is felt to be a vast improvement over the "see one, do one" learning experience so common on the obstetrical services.

(3) Hospital and public health administrators see this as a piece of the solution to manpower shortage with not too much concern regarding the uniqueness of the contribution of the nurse midwife on the health team.

(4) Patients who have received obstetric care in other settings are enthusiastic about nurse midwifery, whether the previous experience be private obstetrics, medical student or resident delivery. The reasons are three: First, most nurse midwives are women; Secondly, there is a continuity of care in most services, so that the nurse midwife who follows the patient in labor and delivers her is somewhat already known by the patient as someone who had followed her in clinics; Thirdly, "nurse midwives don't hurry patients through clinic. Nurse midwives are patient. You can ask questions. They don't mind sitting in your labor room for hours on end." Some of us M.D.'s have learned to do this, but our knuckles are white and our jaws clenched.

I have spoken of the commonest role of the American nurse midwife as the employee of county and city health departments and hospitals. Much less frequently, she is employed by a physician as an associate. In such a role, she follows patients prenatally, follows in labor and delivery those who are normal, and assists in following the abnormal. I have heard of nurse midwives in independent private practice but have no documentation of this; and, for purposes of this discussion, we may regard this as unfounded.

Let us now turn to her role as regards function, rather than status. Here we find a whole spectrum, depending upon the skills of the nurse midwife, as well as the needs of the obstetric community. At the conservative end of this continuum is a nurse midwife functioning in a city hospital with plenty of residents and really no need to do more than spontaneous deliveries, episiotomies, perineal laceration repairs. At the other end is the practitioner in the African bush, where there's no physician within a hundred miles, who must be able to do a Cesarean section on a patient bleeding from a central placenta praevia if the patient's life is to be saved.

Between these two extremes is the role in most

places in this country. At the first prenatal visit, the history, physical examination and laboratory work is reviewed by physician and the nurse midwife. If satisfactory to both and to the patient, the case is assigned to the nurse midwife, and she follows the patient through the rest of her prenatal course, seeking consultation should any abnormality arise. She has a set of routine medications that she may use for vaginitis, constipation, etc. She admits and follows the patient in labor with a set of routine medications she may use for sedation, oxytocic action after delivery, after pains, and the routines for postpartum care and contraceptive selection. In this role, the nurse midwife is now functioning in many hospitals throughout the United States, including such places as Roosevelt and Kings County Hospital in New York City; the Johns Hopkins Hospital and Baltimore City Hospital in Baltimore; Cook County Hospital, Chicago; University Hospital, Salt Lake City, Utah; and Grady Memorial Hospital, Atlanta. Schools of nurse midwifery try to teach individuals at either end of this spectrum of need, depending on the student's ability, desires, and the community needs where she plans to practice.

I thought you would be especially interested in what happens when two nurse midwives enter upon the caseload of a non-urban community in Georgia. (Table 1) Together they did the work of an obstetrician/gynecologist with a moderate sized gynecology practice, some teaching responsibility, and some clinical research. With one more nurse midwife, they could easily double their deliveries; and, with two more, the load could be quadrupled. This, costwise, would be about the cost of one full-time gynecologist/obstetrician, who in no way could do the job and, even if he did, would undoubtedly move on to greener pastures or commence trading off obstetrics for gynecology within a few years.

Granted then that this is a way to solve health manpower shortages, that it is an economically feasible way of doing so, that it frees a physician to perform where the need of his abilities is the greatest, how do patients feel? I'll close with a pardonable anecdote: In 1963 to 1965, I was without a partner in a part-time practice. It was not a usual clientele, but was composed largely of faculty wives from several of the local universities. I secured the services of a nurse midwife, who saw my patients every other visit in the office, rounded on them in the hospital every other day, and followed them in labor and delivered normal patients on my office days and every other night. If the patient in labor had a problem, we traded places during the daytime and traded nights off if it was at night. All but one of the patients were enthusiastic and felt a new dimension of care had been made available to them. The one was a physician's wife, and I gave her assurance of my personal care and she got along fine, anyhow. Other reports from physicians are similar.

Pogo says, "We have met the enemy and he is us." If we convince ourselves about the role of the nurse midwife in private practice, as well as for the care of the indigent, we have nothing to fear from our patients. ■

TABLE 1

NURSE MIDWIFERY IN A GEORGIA COUNTY

July 1, 1972 through June 30, 1973

Nurse midwife	130
R.N.	2
N.M.W. and M.D.	13
M.D.*	24
Unknown	1
TOTAL	170

*** M.D. deliveries: 7 D&C and/or abortion, 7 cesarean sections, 3 forceps, 2 prematures, 1 placenta previa, 1 prolonged rupture of membrane, 2 walk-ins, 1 for NMW—No complications.**

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The author expresses a unique insight into the ramifications of medical history.

Four Main Threads in Medical History

STEPHEN W. GRAY, Ph.D., *Atlanta**

THE HISTORY OF MEDICAL PRACTICE is a plexus of ideas, branching and anastomosing, through which four main trunks or threads can be traced. At any one time some threads are more important than others, but each is always present, implicitly or explicitly in the mind of the physician, the patient or both. The four threads, in order of age, are Magic, Religion, Observation and Experiment. Each contributes to, and draws from the others.

Amulets and Talismans

Magical therapy with its spells, amulets and talismans has always been used in treatment of the sick. It is successful in four important ways:

1) The patient wants *action;* magical therapy provides it.
2) The patients wants to know *why* he is sick; the magician can identify his enemies.
3) The patient feels isolated by his illness; the magician can rally the community around him.
4) The healthy are frightened by the patient's illness; magic can reassure them and restrain panic.

Each of these encourages support of the patient by the community and raises the patient's morale.

We need to remind ourselves of the nature of primitive magic as opposed to modern theatrical slight-of-hand. Primitive magic has a few simple attributes found all over the world. Magic is logical on its premises, even when the premises themselves are absurd. Magic is rarely trivial and does not replace hard work. Thus, minor ailments are treated rationally; serious ailments require magical therapy. The ailments themselves may be magical, resulting from an enemy's spell.

Magic is based on emotion; all healing is performed with strong feeling. A detached magician could cure no one. A patient who does not wish to get well cannot be reached by magical therapy. The magic power is in the physician; he is never wrong, but his magic may be weak. The magic power is secret; it is not invented nor deduced from observation. It is revealed to the magician and passed on by transcendental experience as well as by teaching, but merely knowing a spell will not make it work for you. The power as well as the knowledge must be present.

Magic does not change. If you have the power, you can learn from books and practice magic today.

Body and Soul

The thread of Religion has two conflicting strands for the Christian. On the one hand is Christ the Healer with his admonition to the believer to care for the sick. On the other hand is the conviction that the body is vile and of no worth compared to the soul. Healing is of little importance compared to salvation.

In addition, the Christian tends to suspect rational medicine since reason is dangerous to faith. The physician's therapy may be in opposition to God's will. This view, widespread in early Christianity, now appears overtly only among a few extreme sects, but it lingers beneath the surface of the minds of many other Christians. The dilemma is often resolved by assigning to the physician magical powers derived from God. Thus God heals through his agent the physician.

Observation, our third thread, was a basis of healing since before written history, but systematic, recorded observations first appeared in Greece. The background centered on the cult of Asklepios, a physician and son of Apollo, who received his skill from his father and his knowledge from the centaur Cheiron. Asklepios was eventually killed by Zeus for teaching the art to mortals. As Prometheus and

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Adam also discovered, knowledge can be dangerous. The magical elements are obvious.

From this cult of Asklepios arose a new concept of rational medicine: "to offer up prayers is no doubt becoming and good, but while praying to the gods a man ought also to use his own exertions."

Hippocrates, an Asklepiad priest living during the great period of Greek civilization, began to formalize rational medicine. He specifically repudiated emotion and secrecy. To Hippocrates, faith was not necessary: "Even those who do not believe in it (the art of Medicine) can be cured by it." Almost as radical was his disregard of secrecy: "I look upon it as a great part of the Art to be able to judge properly of that which has been written."

Hippocrates himself left 47 well written case histories. Interestingly, more than half had a fatal outcome. These were to be the best case histories written for 1700 years. He also left works on professional practice, ethics and law in medicine as well as research notes and the famous "Aphorisms" used to teach students. The first Aphorism sets out the requirements of rational therapy without regard to magic or religion: "Life is short and Science is long; opportunity is elusive, experiment is dangerous, judgement is difficult. It is not enough for the physician to do what is necessary, but the patient and the attendants must do their parts as well, and circumstances must be favorable."

Rational Medicine Vanishes

From the fourth century B.C. to the second century A.D.—from Hippocrates to Galen—rational medicine blossomed only to disappear almost completely. Two causes are usually assigned: First, the spread of Christianity with its emphasis on faith, and its hostility toward pagan writers, and second the appearance of a number of pandemics of bubonic plague and smallpox that rational medicine was unable to treat or even explain effectively. The accumulation of observations which might have resulted in medical progress did not take place. Hippocrates' work was revered, but his methods were not continued.

To us, observations suggest experiments which in turn produce new observations resulting in medical progress. Experiment in antiquity existed only as random empiricism without system or rationale. Why this was, requires an understanding of the idea of progress itself.

For nearly two millennia after Hippocrates, the obviously imperfect nature of man was viewed as a degeneration from a Golden Age—the garden of Eden, the age of Pericles or of Augustus. Everything used to be better; everything is now worse. Our ancestors were wiser and better men than we can hope to be.

For the Christian there was the promise of the Millennium, not to be reached by human effort, but by Divine Will. Only one's own soul can be improved. Disease is punishment for sin in the unbeliever and a test of faith by God in the believer.

A Better Life

The idea of progress, and with it the importance of systematic observation and experiment, took form slowly in men's minds. The new idea was that man and his lot, however imperfect, might be improved. Two books were published in the year 1543: *De Humani Corporis Fabrica* of Vesalius and *De Revolutionibus Orbium Coelestium* of Copernicus. Vesalius believed he was simply adding new facts to Galen's anatomy which was, of course, correct, only incomplete. But Galen's anatomy was all but lost in the new facts so clearly presented by Vesalius. Copernicus started to correct known mistakes in Ptolemy's astronomy and ended by producing an entirely new theory to fit the corrected observations.

We usually think of the contributions of Vesalius and Copernicus to the progress of their respective sciences without noticing their even more important contribution to the idea of progress itself. We need not feel embarrased; there is no evidence that they were aware of it either.

Although a start had been made, it was the next century that produced a formal recognition that progress was not only possible but something to be actively sought. Descartes set forth two ideas without which experiment was hardly possible. The first was the idea of the supremacy of Reason over Faith; the second was the concept of the invariability of the laws of Nature and the denial of the capricious intervention of Providence.

Slightly earlier Francis Bacon formally described the experimental method and its application to the progress of knowledge. He further stated that the knowledge so gained is not to be solely for the satisfaction of a few scholars but "the proper aim of knowledge is to increase men's happiness and alleviate their suffering." This was as radical as Hippocrates' statement that a patient could be cured without faith.

The idea of progress by systematic experiment was not, of course, instantly applied to medical practice or to anything else. Nevertheless, advances in medicine were made by Harvey, Morgagni and the Hunters. Social progress was implicit in the French Revolution, it became explicit in the revolutions of 1848, but it has been said that the Crystal Palace

Exposition in London in 1851 at which advances in technology of transportation, construction and manufacture brought the idea of Progress to the general public in terms no one could fail to understand. It became apparent to everyone that Bacon's predictions might be fulfilled. It was at this time that the miracle of anesthesia appeared on a dramatic scale to "alleviate their suffering."

For another hundred years Progress looked fine. Observation and Experiment were triumphant over Religion and Magic. Religion adapted to rational medicine and magic went underground into the subconscious of rational men and became the curious superstitions of the "lesser breeds."

Search for Simplicity

Triumph tends to incite reaction. At present the immense and increasing complexity of medicine has aroused a rebellious search for simplicity. There is a revival of astrology and the magic of antiquity. More strikingly a new magic of "natural" foods and mind altering life styles has arisen. Disease is looked upon as a consequence of the complexity of life rather than something that an increasingly sophisticated practice of medicine may be able to cure. An obvious example of this reaction is the welcome acupuncture has received. Regardless of any possible worth, acupuncture appeals to an old irrational sense of mystery and of simplicity. That it cannot be understood by physicians is the major factor in its acceptance. The sometimes mindless, logical advance of science in all fields, has turned many away from Bacon's vision. We can expect an increase in mystic and emotional simplistic cults to remind us that the appeal of Magic and Religion never quite dies. The rational and irrational can co-exist in the human mind with surprising ease. ■

Variety Characterizes 1974 Atlanta Graduate Medical Assembly

Intensive care units, once rare but now generally available in hospitals around Georgia, will be the subject of a full day of discussion for physicians attending the 31st annual Atlanta Graduate Medical Assembly March 4-6 at Stouffer's Atlanta Inn.

William C. Waters, M.D., a member of the Assembly executive committee, said the intensive care unit (ICU) session is a new feature of the program and reflects a "keen interest and some controversy among physicians in various specialties, as well as hospital officials, in future directions of ICU therapy."

The ICU session, on Wednesday, March 6, will include lectures and presentations on the management of patients with various conditions requiring intensive care therapy; and a luncheon symposium on ICU organization, personnel and hardware.

Duncan Shepard, M.D., general chairman of the Assembly, said another first-time specialty topic will be gastroenterology, with an entire day of lectures on Tuesday, March 5.

The Assembly, sponsored by the Medical Association of Atlanta, is one of the largest post-graduate medical programs in the Southeast. Dr. Shepard said the Assembly is fully approved for credits by the Georgia Chapter of the American Academy of Family Physicians.

The first day of the Assembly, Monday, March 4, will be devoted to concurrent, full-day sessions on surgery and cardiology. Sidney Goldstein, M.D., chief of cardiology at Rochester (N.Y.) General Hospital, will lecture on "Sudden Death." Another cardiology topic will be "Newer Pacemakers," by Seymour Furman, M.D., professor of surgery at Albert Einstein College of Medicine, Bronx, N.Y.

Four main subjects will be covered in the sessions on Tuesday, March 5. They are "Gastroenterology," "Cancer," "Obstetrics," and "Pediatrics and Family Medicine."

Hiromi Shinya, M.D., of New York City, will be a featured speaker during the "Gastroenterology" session. Dr. Shinya's two lectures will include "Fibrocolonoscope, Therapeutic Applications."

Joining the Medical Association of Atlanta as cosponsors of various specialty parts of the Assembly program are the following organizations: Georgia Heart Association; Georgia Chapter, American College of Surgeons; the American College of Physicians; Georgia Division, American Cancer Society; the Atlanta Obstetrical and Gynecological Society; the Georgia Academy of Family Physicians; the Greater Atlanta Pediatric Society, and the Georgia Society of Internal Medicine.

Other members of the AGMA executive committee are: Carter Smith, Jr., M.D., faculty and curriculum chairman; Judson L. Hawk, Jr., M.D., exhibits chairman; Alton V. Hallum, Jr., M.D., audio visual chairman; William C. Waters, III., M.D., hospitality chairman, and Mrs. Wynnell S. Hopkins, executive secretary.

A ladies program for wives of physicians attending the Assembly will include a visit to the Memorial Arts Center and the High Museum, and an inside visit to three of Atlanta's elegant private homes. A luncheon for the wives will be held in Stouffer's Atlanta Ballroom and will feature a fashion show by Saks Fifth Avenue.

Mrs. Fleming L. Jolly and Mrs. Parry Soder are co-chairmen of the ladies program and Mrs. Carter Smith, Jr., is hospitality chairman.

Contact the Medical Association of Atlanta, 875 W. Peachtree St., N.E., Atlanta, Ga. 30309 for additional information.

PSRO Is Here

THE MAG HOUSE OF DELEGATES, at a called meeting in Atlanta in December 1973, heard a report from the Ad Hoc Study Committee on PSRO. The comprehensive report has been published in the January issue of the **Journal of the Medical Association of Georgia.** It was considered and approved by the MAG House, serving as a committee of the whole.

The appraisal of the study committee is that the law is poorly conceived in several areas, will interfere with the personal relationship and confidentiality between physician and patient, will discourage innovative approaches to medical problems, will increase the threat of malpractice suits and ultimately will inflate the overall cost and utilization of medical services. Physician time needed for patient care will be spent on administrative detail and in committee meetings. An entire, new bureaucracy will be established to set the pattern of medical care delivery, and concern was expressed that a bureau cannot treat a person as well as can a physician. In addition, historically, bureaus have not been notably efficient.

House of Delegates Action

After reaffirming its commitment to the principle of peer review and the need for a method of accountability where public funds are being spent, the MAG House of Delegates agreed on the following course of action: 1) Work to repeal PSRO, since it is not considered to be a good law. 2) In the meantime, institute no action to implement the law. Organized medicine has two years in which to make this decision. 3) Make an intensive effort to inform the profession and the public about the potential problems and weaknesses of the law, emphasizing at the same time that our present delivery system, although imperfect, is basically sound and efficient and worth preserving. 4) Begin to plan an alternate course of action, developing a mechanism through which we can assume control of the review mechanism, if efforts at repeal fail and this becomes desirable.

After all of this has been said, what are the realities of the situation? The world is going to change for the physician and his patient, to what extent has not yet been decided.

Two Responses

In meeting this crisis (a time when change is inevitable, for better or for worse), we in organized medicine can respond basically in one of two ways. We can react, blame the liberal politicians, the news media, the AMA, or political pressure groups and conclude only with reaction. Likely, in this case, we will eventually decide that, as Pogo once said, "We have met the enemy and he is us."

We have, as practitioners, been so busy delivering the best medical care in the world that we have not taken time to work at the politics of medicine. We have not provided input in deliberations of our county societies, the MAG, or

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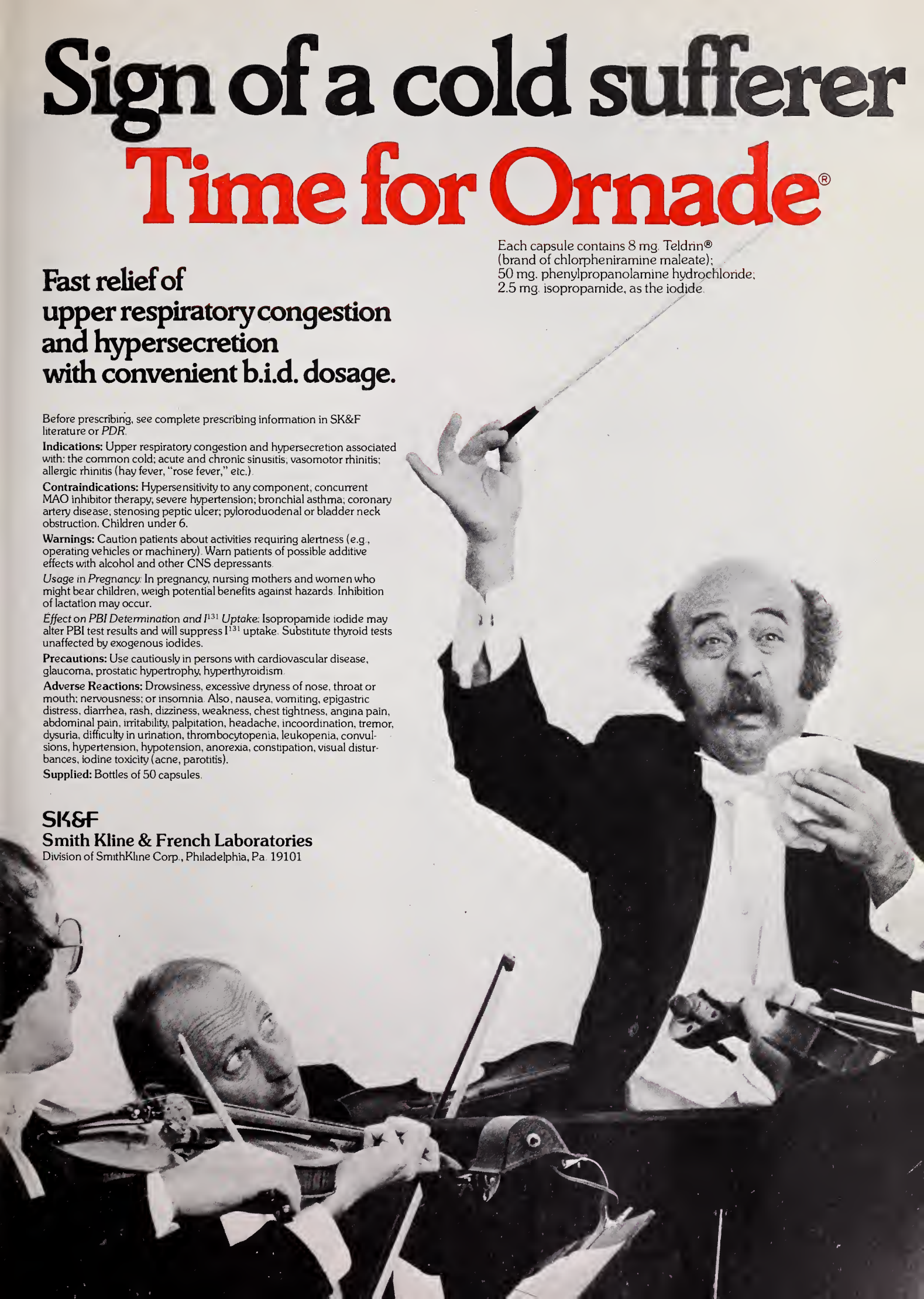
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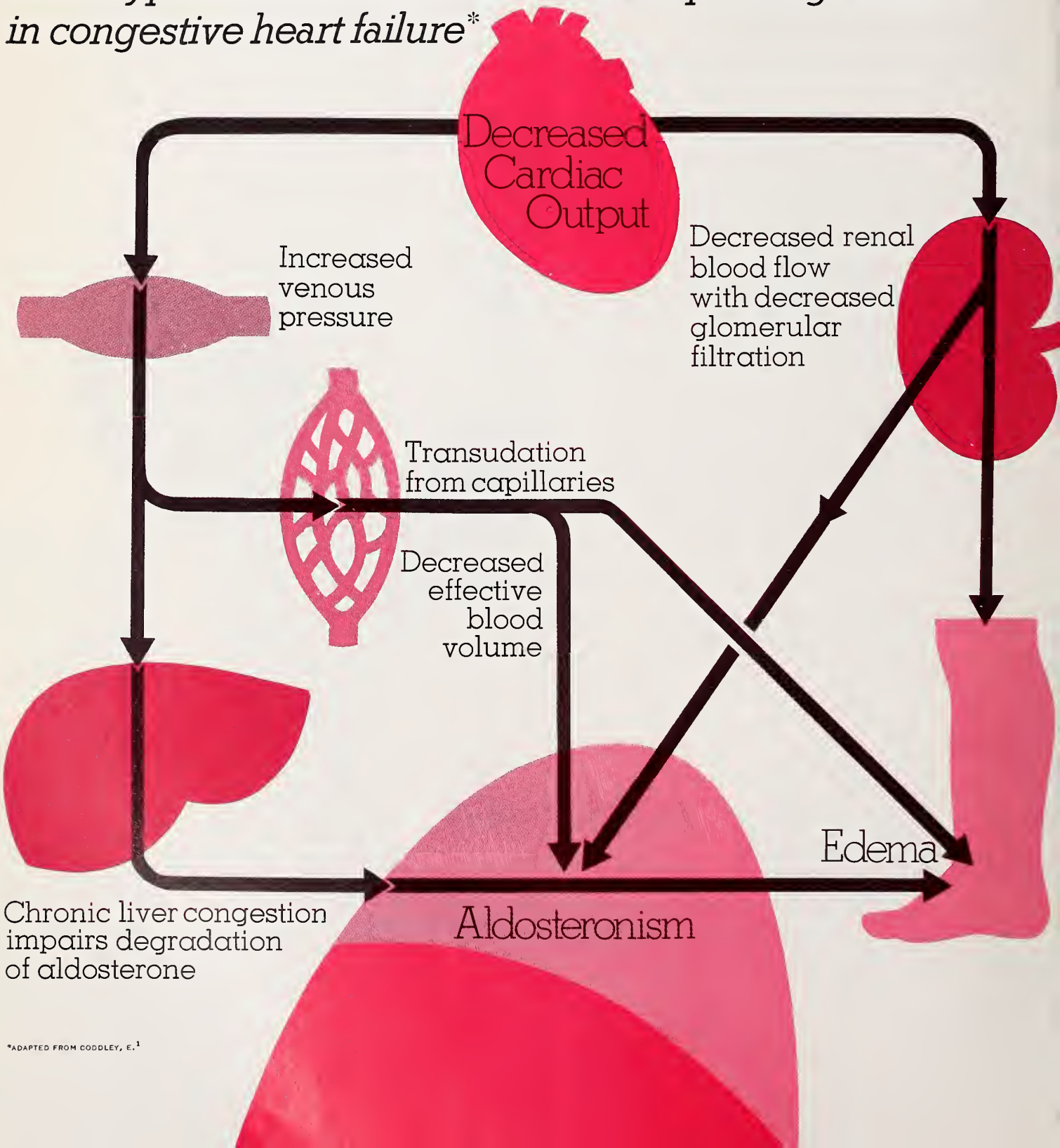
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- Aldactone plus "A.D.D." schedule minimizes potassium deficiency and potentiates effect of "add-on" diuretic.[2]
- Avoids acute volume depletion and aldosterone rebound.[2]

3. As a daily diuretic in combination with a daily dose of a thiazide

- Permits daily additive diuretic effect while maintaining potassium balance.

Indications—Essential hypertension; edema or ascites of congestive heart failure, cirrhosis of the liver and the nephrotic syndrome; idiopathic edema. Some patients with malignant effusions may benefit from Aldactone (spironolactone), particularly when given with a thiazide diuretic.

Contraindications—Acute renal insufficiency, rapidly progressing impairment of renal function, anuria and hyperkalemia.

Warnings—Potassium supplementation may cause hyperkalemia and is not indicated unless a glucocorticoid is also given. Discontinue potassium supplementation if hyperkalemia develops. **Usage of any drug in women of childbearing age requires that the potential benefits of the drug be weighed against its possible hazards to the mother and fetus.**

Precautions—Patients should be checked carefully since electrolyte imbalance may occur. Although usually insignificant, hyperkalemia may be serious when renal impairment exists; deaths have occurred. Hyponatremia, manifested by dryness of the mouth, thirst, lethargy and drowsiness, together with a low serum sodium may be caused or aggravated, especially when Aldactone is combined with other diuretics. Elevation of BUN may occur, especially when pretreatment hyperazotemia exists. Mild acidosis may occur. Reduce the dosage of other antihypertensive drugs, particularly the ganglionic blocking agents, by at least 50 percent when adding Aldactone since it may potentiate their action.

Adverse Reactions—Drowsiness, lethargy, headache, diarrhea and other gastrointestinal symptoms, maculopapular or erythematous cutaneous eruptions, urticaria, mental confusion, drug fever, ataxia, gynecomastia, inability to achieve or maintain erection, mild androgenic effects, including hirsutism, irregular menses and deepening voice. Adverse reactions are infrequent and usually reversible.

Dosage and Administration—For **essential hypertension** in **adults** the daily dosage is 50 to 100 mg. in divided doses. Aldactone may be combined with a thiazide diuretic if necessary. Continue treatment for two weeks or longer since an adequate response may not occur sooner. Adjust subsequent dosage according to response of patient.

For edema, ascites or **effusions** in **adults** initial daily dosage is 100 mg. in divided doses. Continue medication for at least five days to determine diuretic response; add a thiazide or organic mercurial if adequate diuretic response has not occurred. Aldactone dosage should not be changed when other therapy is added. A daily dosage of Aldactone considerably greater than 75 mg. may be given if necessary.

A glucocorticoid, such as 15 to 20 mg. of prednisone daily, may be desirable for patients with extremely resistant edema which does not respond adequately to Aldactone and a conventional diuretic. Observe the usual precautions applicable to glucocorticoid therapy; supplemental potassium will usually be necessary. Such patients frequently have an associated hyponatremia—restriction of fluid intake to 1 liter per day or administration of mannitol or urea may be necessary (these measures are contraindicated in patients with uremia or severely impaired renal function). Mannitol is contraindicated in patients with congestive heart failure, and urea is contraindicated with a history or signs of hepatic coma unless the patient is receiving antibiotics orally to "sterilize" the gastrointestinal tract.

Glucocorticoids should probably be given first to patients with nephrosis since Aldactone, although useful for diuresis, will not directly affect the basic pathologic process.

For **children** the daily dosage should provide 1.5 mg. of Aldactone per pound of body weight.

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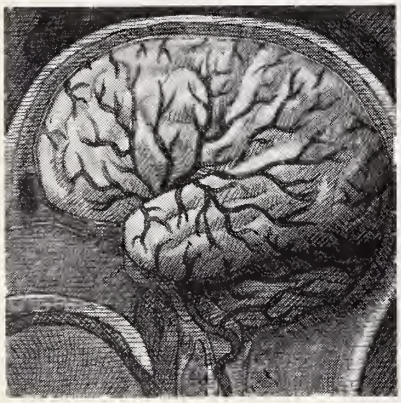
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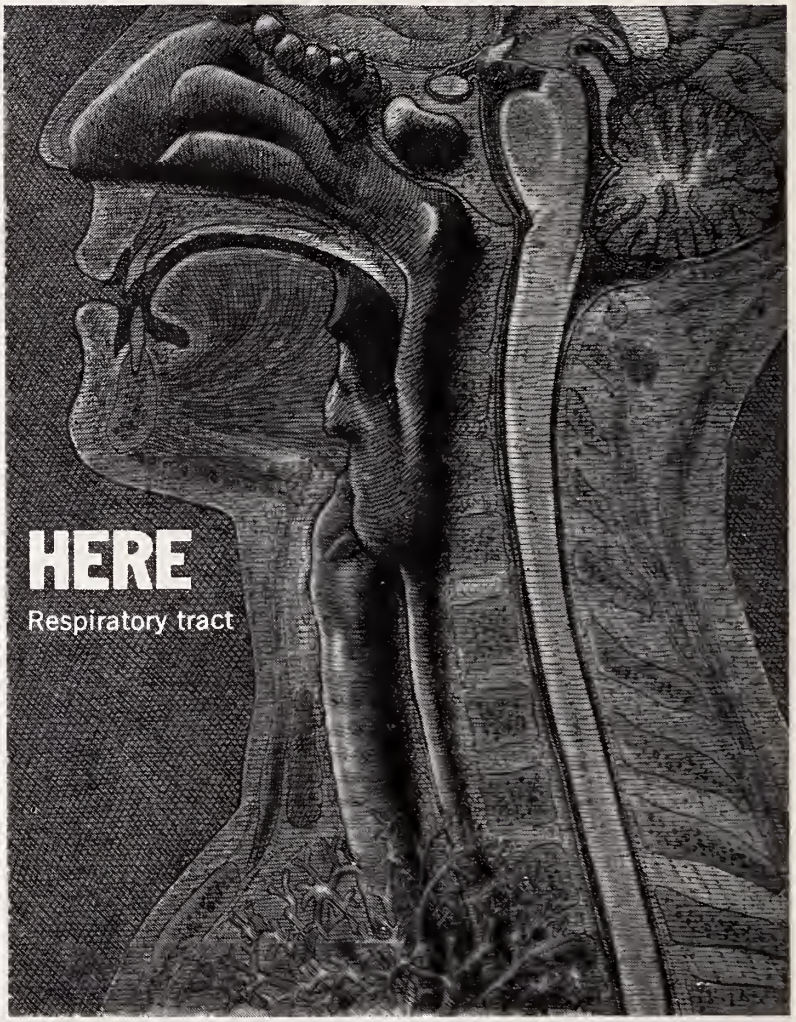


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the AMA, and have not developed an effective public relations program. Our academic colleagues have remained aloof and have not offered to help us find answers to the delivery problems at the community level. We have been critical of our congressmen for being unaware that the PSRO section was in the 1972 Social Security bill, and yet only a few of us still, 15 months later, are concerned enough to study the law and discuss it with our patients and political friends. We want somebody else to "do something." We have reviewed ourselves extensively but have not been vigorous enough or vocal enough to eliminate the over-utilization and the substandard practices of the very small minority among us. As a result, the government, and, significantly, the government of the people, has moved in. Typical of government, a treatment has been devised which is worse than the disease.

What should we do now? We can cry out in alarm and then be done with it.

Or, as an organized group, we can identify the problems in PSRO and in the present system, "reason together," and proceed to offer solutions which are consistent with the nature and magnitude of the problems we find.

Study, Consider, Act

We can study, consider, and then act. We can be persuasive in pointing out that we, too, are concerned about the cost and type of care being rendered, and that we are ready to provide an appropriate and better means of curtailing costs and assuring quality. We can yet alter the thrust of the PSRO law, but only by devoting ourselves with the same energy and dedication toward improvement of the system of medicine that we have traditionally manifested toward the delivery of good care for the patient. The sounding of alarm is instinctive and reflex when we see radical, and perhaps threatening, change on the horizon. Once alerted, however, we can begin to direct the inevitable change, as only physicians have the competence to do, preserving for medicine the environment which allows us to provide personal, good, and sufficient medical services, free of rigid government controls.

"PSRO," or its counterpart in principle, is here. Its time has come. We can try to repeal the current law or work to improve it, but since we are spending tax money, we must accept the concept of review and accountability. And ultimately, in a mature and responsible way, we must devise the mechanism and learn to control it and live with it, for the good of the profession and the public.

Charles D. Hollis, Jr., M.D.

Hunting the "Silent Killer"

FEBRUARY IS HEART MONTH in Georgia. The annual HEART FUND drive of the Georgia Heart Association will serve this year as a statewide vehicle for educating the public about one of the state's most serious health problems —high blood pressure.

"Project HBP Control," conducted by Heart volunteers throughout February, and on into the year, will focus on detecting and bringing under control this "silent killer" which afflicts an estimated 800,000 Georgians, about one in every five.

Six high blood pressure centers have been established under Heart grants at strategically located clinics to provide routine blood pressure checks to patients. The effort is designed to feed back vital information about the incidence of high blood pressure in various populations and how it might be affected by sex, age, weight, geography and other factors.

New materials for patient education in high blood pressure have been de-

signed and produced by the Heart Association for pilot testing in several areas.

Fifth Graders Learn Techniques

A school program which teaches high blood pressure detection techniques to fifth, sixth and seventh graders has been successfully tested in Carrollton and is now being conducted in Gwinnett County. Other county schools systems are scheduled to take up the program as soon as equipment is available. The program's primary benefit is one of public awareness, but the Carrollton project showed that there is a rewarding degree of accuracy in reports from the elementary school students. All reports indicating elevated blood pressures were followed up by a team of volunteer medical professionals.

The Central Georgia area has undertaken a Heart-sponsored public education project to educate people in that area about the dangers of untreated high blood pressure. Representatives of the news media, local Heart Unit volunteers and officers, medical professionals and others in the area have begun working together in a pilot plan to test the effectiveness of a saturation campaign to teach people about high blood pressure and motivate them to contact their physician or clinic to have a blood pressure check.

Heart Sunday, February 24

These efforts throughout the state will be supported by more than 50,000 Heart volunteers who will visit door-to-door on February 24, Heart Sunday, to distribute educational leaflets about high blood pressure and receive contributions for the HEART FUND.

The problem of high blood pressure is very much in the limelight this year and Georgia is one of the states leading the nation in efforts to deal with the problem.

The Georgia Heart Association's programs have attracted federal money to the state this year to help find and control this mysterious disease which often can result in heart attack, stroke, and kidney failure, yet seldom causes discomfort to the victim.

"Project HBP Control" is one more example of the Heart Association's ability to channel volunteer services and public contributions into viable, life-saving health programs which benefit all of Georgia.

president's letter



Campaign for Repeal Begins

THIS IS BEING PREPARED immediately following the meeting of MAG Council in Atlanta January 12 and 13.

Your MAG House of Delegates directed, at the called meeting in December 1973, that we provide funds and work for repeal of the PSRO law.

A broad and comprehensive plan has been prepared and approved at this meeting of Council to accomplish this goal. Council approved a tentative budget of up to $60,000 for implementation of this plan. The plan will involve every member of MAG. You will be contacted by letter, through the *Journal of MAG,* by your councilor and perhaps by telephone from the headquarters office. We will mount an intensive campaign to solicit help from AMA, other state medical societies, sympathetic allied professions and our patients. You must inform your congressman and senator in no uncertain terms that you wish repeal of Section 249-F of Public Law 92-603, the PSRO law!

Will we be successful? I don't know. I feel that if the majority of physicians in Georgia and the United States want it repealed, or perhaps favorably modified, it will be done; but we must expend large amounts of time, energy and money in order to do so. When you are called upon, please do your part.

The Executive Committee and Council unanimously voted to actively and vigorously support John Heard, president of the DeKalb County Medical Society, in his bid for appointment or election to the AMA Board of Trustees. AMA and organized medicine will most certainly benefit should John gain this position and MAG will gain an effective and intelligent voice in AMA.



Charles Emory Bohler, M.D.
President, Medical Association of Georgia

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The Stilbestrol Child

ERNEST W. FRANKLIN, III, M.D., AINSWORTH G. DUDLEY, M.D., *and* THOMAS A. CAPUTO, M.D., *Atlanta**

CLEAR CELL CARCINOMA of the vagina or cervix is a rare tumor which in the past has been reported almost exclusively in older women. Herbst and Associates noted eight such cases of clear cell carcinoma occurring in young girls between 15 and 22 years of age. These authors noted that the mothers of seven of these patients had received diethylstilbestrol during their pregnancy. Since this original report over 100 such cases have been discovered. Furthermore, all nonsteroidal synthetic estrogens are suspect as similar cases have been reported with dienestrol and hexestrol. The dose and duration of therapy have varied widely. As little as 1.5 mg. stilbestrol daily taken throughout pregnancy and administration of the drug for as short an interval as 12 days during the first trimester have both been associated with the tumor appearance in offspring.



FIGURE 1

Illustrates the transverse vaginal ridge (R) sometimes associated with clear cell carcinoma of the vagina or cervix (C). Note the area of adenosis (A) which appears as an erythematous area in the vagina. (Photograph courtesy of Dr. Arthur Herbst.)

While the risk of tumor development in an exposed female offspring is undeniably quite low and no known risk exists for male offspring, it is now apparent that some method should be devised to follow and examine these young females. The tumor may present in many ways; however, it usually is associated with vaginal bleeding or staining. As a consequence any variation of normal menses must be thoroughly evaluated. This includes those patients in which there is no definite history of maternal ingestion. It is equally important to examine all patients with a history of maternal stilbestrol ingestion regardless of symptoms as a number of asymptomatic cases have been diagnosed by this means.

Scheme of Evaluation

What then is considered a reasonable examination of such patients? The following scheme of evaluation is now utilized on the Gynecology Tumor Service at

* From the Division of Gynecologic Oncology, Department of Gynecology and Obstetrics, Emory University Clinic, 1365 Clifton Road, N.E., Atlanta, Ga. 30322.

Emory University and also approximates that advocated by the American College of Obstetrics and Gynecology.

1. A complete pelvic examination, possibly under anaesthesia, must be performed with inspection as well as palpation for slight induration or nodularity of the vaginal membrane. Careful attention should be directed to the entire vaginal membrane; therefore, the speculum must be rotated and slowly withdrawn. Occasionally roughened areas may be palpated when not visualized. A constriction band in the upper vagina has been reported as a benign congenital anomaly frequently occurring in these patients; if noted, these patients are more suspect. Those areas which appear red or faintly blushed on the vagina or ectocervix may represent benign adenosis or carcinoma and should be biopsied.

2. A Pap smear should be performed, though it should be pointed out that this may be of little value because this neoplasm occurs subepithelially and therefore does not exfoliate cells until late in the disease process. The pathologist should be alerted to the possibility of this lesion on the cytology requisition.

3. Schiller's stain should be applied to the vagina and cervix. Because of overlying squamous metaplasia the vaginal membrane overlying or adjacent to areas of adenosis or neoplasm often does not stain; consequently, a selected site for biopsy may be obtained.

Those patients in whom the exam is normal are followed at six month intervals. In approximately 30 percent of patients benign adenosis will be observed without evidence of neoplasia. It is our practice to follow these patients at shorter intervals, usually every three months.

In conclusion, until further light is shed on the incidence of clear cell carcinoma of the vagina and cervix following maternal ingestion of nonsteroidal synthetic estrogens, patients must be examined thoroughly, stained and biopsied when necessary and followed with careful and frequent pelvic examinations. Furthermore, carcinoma of the vagina should now be considered in all young girls presenting with irregular vaginal bleeding and excluded by thorough vaginal examination. ■

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Angina Pectoris and Aortic Valvular Disease

JOSEPH W. RUBIN, M.D., *Augusta**

THE ONSET OF ANGINA PECTORIS in a patient suspected of having significant aortic stenosis is frequently considered one of the indications for hemodynamic study and valve replacement. Before the advantages of direct myocardial revascularization were propounded, little attention was accorded the coronary circulation in the evaluation of a stenotic or insufficient aortic valve. Then, coexisting coronary artery disease was considered a complication casting gloom upon a successful outcome to valve replacement.

Significance in Evaluation

Yet, coronary artery disease cannot always be demonstrated angiographically when chest pain complicates an aortic valve lesion. The occasional unexpected early demise of a patient following aortic valve replacement in whom no coronary artery disease could be demonstrated, adds special significance to angina pectoris in the overall pre-operative evaluation. At post-mortem in these instances, the main coronary arteries are often disease free, dilated and tortuous. The significant vascular obliterations are found microscopically at the arteriolar level deep within the layers of concentric ventricular hypertrophy.

To complete the circle of uncertainty, there is the occasional patient who defies all ominous portents based on inadequate ventricular function, diseased coronary arteries and past myocardial infarctions who survives valve replacement. However, the functional rehabilitation of these patients may be curtailed by progressive coronary artery disease.[3]

Current experience indicates that in individuals with coronary insufficiency alone the anatomic locations of arterial obstruction rather than past history of infarctions and symptoms consistently correlate best with the occurrence of sudden death. Proximal left coronary lesions and triple vessel disease are particularly significant.[6] Unstable angina confirmed by electrocardiographic evidence of ischemia is an additional sign of great risk.[5]

Success With Combined Procedures

The achievement of satisfactory relief of both chest pain and impaired ventricular function due to stenoses of major coronary arteries by means of direct myocardial revascularization has led several surgical groups to successfully combine coronary bypass drafting with valve replacement in patients at high risk from both coronary atherosclerosis and aortic valvular disease. In early 1972 Anderson et al

* Assistant professor of surgery (thoracic and cardiac surgery) at the Medical College of Georgia, Augusta, Ga. 30902.

reported combined valve replacement and direct revascularization of the heart in 15 (poor risk) patients with no operative deaths.[1] A year later, the same authors write about an expanding series of patients who have had combined surgical procedures with equally excellent results.[2] The data of Cooley et al using the simultaneous attack on valvular and coronary artery disease are also exciting. Their early mortality was 15 per cent after aortic valve replacement and saphenous vein bypass grafting of coronary obstructions. However, when aorto-coronary bypass was delayed and performed only as a resuscitative effort soon after valve replacement, none of these patients survived.[4]

Although the risks of aortic valve replacement remain high in the presence of significant coronary artery disease, simultaneous surgical correction of both conditions is an approach deserving optimism. Careful patient selection with the aid of critical hemodynamic and angiographic evaluation and precise intra-operative and post-operative care will eventually enhance the safety of this aggressive combination of procedures. ■

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Brunswick Becomes Headquarters for Trauma Society

A non-profit organization concerned with the care of the critically ill and critically injured, the American Trauma Society, Georgia Division, Inc., has been set up with headquarters in Brunswick, according to Acting Director Stewart McClain.

E. R. Jennings, M.D., founder of the Society, describes the corporation as "exclusively non-profit and was founded to save the lives of critically injured and critically ill patients through education and training of specialized personnel, encouragement of research and voluntary contributions for the study and treatment of trauma; to create community programs to prevent injuries, improve the care of the injured and to minimize the disability therefrom."

McClain feels that the Society can be of particular importance in the Golden Isles area due to the inaccessibility of hospital facilities to Sea Island, St. Simons Island, Jekyll Island and outlying areas. He hopes the Society can coordinate the transportation of the ill and injured by boats, intensive-care vans and helicopters when funds are available.

A pilot program is planned for the local area to establish set procedures for the transportation and treatment of the ill and injured. Results of the program will be utilized by other units in the state upon completion of the program.

Tax-deductible contributions may be sent to 2432 Parkwood Drive, Brunswick, Ga. 31420 and made payable to the American Trauma Society.

legal page
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legal page

New Federal Health Maintenance Organization Act

J. WINSTON HUFF, *Atlanta**

In December of 1973 Congress passed, and President Nixon approved, the Health Maintenance Organization Act of 1973. The Act provides federal grant funds for feasibility studies and for planning the establishment of Health Maintenance Organizations (HMOs), and federal loan guarantees for losses HMOs may incur in the first 36 months of their operation. It also defines the term "Health Maintenance Organizations," and sets forth what services it must give, who must be served, how HMOs will be governed and regulated and how "quality assurance" will be studied and evaluated. While not as lengthy as most legislation emanating from Congress, it is impossible in this short space to cover every provision of the new Act. Some of its principal points are:

Federal funding: For feasibility surveys and for planning and initial development costs, there is authorized an expenditure of $250 million through June 30, 1977. Also, the Act authorizes loan funds of $75 million through June 30, 1975 to make good the operational losses of HMOs. The loans can be directly from HEW, or may be private loans guaranteed by HEW, and, as to any particular HMO, are limited to $1 million in any year, with a maximum of $2.5 million in the aggregate.

HMO defined: A Health Maintenance Organization is defined as a legal entity (public, or private non-profit) which provides "basic health services" and "supplemental health services" to its "members" and is "organized and operated" as provided by the Act.

"Basic health services" in the Act are described as (i) physician services, (ii) inpatient and outpatient hospital services, (iii) emergency health services, (iv) limited (20 visits) mental health services, (v) treatment of drug and alcohol abuse, (vi) laboratory and radiologic services, and (vii) preventive health services. These services may be provided by a physician, or by a dentist, optometrist or podiatrist if authorized under license by the state. Basic health services shall be available 24 hours a day, 7 days a week. The HMO is authorized to maintain a "drug use profile" on each of its members. "Supplemental health services" include intermediate and long term care, long term physical medicine and rehabilitative services, and mental and dental care not included in "basic" health service.

The "basic health services" are to be paid for periodically at a fixed amount without regard for the date services are provided, nor the frequency, extent or kind of service. The HMO must assume "prospectively" the full financial risk (with some exceptions). It must "enroll persons who are broadly representative of the various age, social and income groups" in its area. It must have an open enrollment period of at least 30 days each year on a first come, first served basis, and cannot expel

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* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, Atlanta, Ga. 30303.

or refuse to re-enroll any member because of his health status or his need for health services." It must also have a "meaningful" procedure for resolving disputes.

One-third of the Board of Directors of an HMO (or other policy making body) must be composed of members of the HMO and there must be "equitable representation" from the "medically underserved" population. It must provide for its members "medical social services" as well as "health education." An HMO must make arrangements for the continuing education of its professional staff as well as an effective reporting and evaluation procedure to be filed with the Secretary of HEW.

Member: A person who has contracted (or for whose benefit a contract has been made) under which the HMO assumes the responsibility for basic health services.

Providing of services: The Act requires the providing of health services by "health professionals" who are either members of the staff of the HMO or who constitute a "medical group" or an "individual practice association."

A "medical group" is defined as a partnership, professional association or other "group" composed of licensed M.D.s, D.O.s (and including dentists, optometrists and podiatrists) a majority of which is licensed to practice medicine or osteopathy *and* the members of which (i) engage, as their principal professional activity, in the "co-ordinated practice of this profession" for an HMO, (ii) pool their income according to a pre-arranged salary or other plan, and (iii) share medical records, equipment and staff. An "Individual Practice Association" is defined as a partnership, professional corporation or other legal entity which has entered into an "arrangement" with persons who are licensed to practice medicine, osteopathy, dentistry, optometry or podiatry. This "arrangement" requires (i) the licensed practitioners to provide their services in accordance with an established compensation contract, (ii) utilization of "other health personnel," (iii) sharing of records, staff and equipment, and, (iv) continuing education.

Community rating system: The HMO (with certain exceptions) must fix its charges under a "Community Rating System" which allows a pre-payment charge to be determined on a per person or per family basis, but equivalent for all individuals and for all families of similar composition.

Integration with employee's health benefit plans: The Act requires that any employer who pays minimum wages and who employs at least 25 employees must include in any health benefit plan the option of membership in an HMO available in its area.

State law: If HEW approves a grant, loan or loan guarantee to an HMO, then no state law can require that (i) a medical society approve, (ii) physicians constitute all or any percentage of the governing board, (iii) any percentage of physicians in the locality be permitted to participate, or (iv) state insurance laws as to capitalization and required reserves be met. Further, no state may enforce any law regulating advertisements or soliciting members for HMOs, but this does not relate to physicians, and health professionals who provide services for an HMO.

Quality assurance programs: Forty million dollars is authorized for the Secretary of HEW to carry out a program respecting "effectiveness, administration, and enforcement" of quality assurance programs. This seems not to be limited to HMOs. The Secretary is required to report on the "quality of health care in the United States," the "operation of quality assurance programs" and "the advances made through research and evaluation of the effectiveness, administration and enforcement of quality assurance programs." The first report is due no later than March 1, 1975. ■

I've told this before . . . .

(Ed. note: The life and death struggle at a watering hole is a familiar theme, replayed on the smaller scale of "Turtles and Doves" in February's story by J. G. McDaniel, M.D., Atlanta. Other physicians and their wives wishing to contribute a human interest story for our pages should contact the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Turtles and Doves

A FRIEND IN ATLANTA told me an interesting story about doves here in the city and how careless they were becoming. I can well believe it, because as a youth in Eastman, Georgia, I tried unsuccessfully for many years to trap a dove, especially in peanut patches, where they were by the hundreds. My father kept telling me "you can trap a quail, but not a dove." Now I catch them in traps set out for chipmunks. For this reason I believe his story.

On the left side of my friend's front porch there is a feeding station for all birds, and down below about 50 yards he has a lily pool some 15 feet across, gradation of rocks, etc. At one time he had a few goldfish in it, but they disappeared—caught by snakes he supposed.

In the cool of the evening while taking a small libation he used to delight in watching the doves feed on the ground under his feeder, then fly down to the lily pool and quench their thirst.

A dove, you know, does not drink like a chicken, that is, suck up water, raise their heads and swallow—they simply suck it up and swallow, never elevating their heads.

On this particular day, my friend had just finished his small modicum of spirits and dusk was at hand, he watched a late dove, a philanderer, no doubt, gorge himself hurriedly and head for the pool. He watched him as he "lit" on a rock covered with little water and commenced to take a draught of good water from the deep pool. Suddenly there was a great clapping of wings, commotion and silence.

My friend, curious, got a flashlight, went down to the pool and there in the clear water was a turtle about six inches wide, about one foot under with the head of the dove firmly held in his mouth.

And this may explain, of course, why wild doves always drink in shallow water, cow tracts, small islands, bog holes, etc.—I have never seen them drink from deep water.

J. G. McDaniel, M.D.

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NEW MEMBERS

Burns, Matthew L. Coweta—Active—SU	15 Cavender St. Newnan, Ga. 30263
Diliberti, Charles P. Bibb—Active—R	Medical Center, Radiology Dept. Macon, Ga. 31201
Filardi, Gerald A. DeKalb—Active—U	755 Columbia Dr. Decatur, Ga. 30030
Gibson, Timothy B. Crawford W. Long—Active—FP	Winterville, Ga. 30683
Gracia, Guido F. Baldwin—Active—N	Central State Hospital Milledgeville, Ga. 31061
Greer, Charles C. Flint—Active—OPH	Box 1115 Cordele, Ga. 31015
Jarrard, George T. Coweta—Active—I	15 Cavender St. Newnan, Ga. 30263
Kurtz, Donald M. Muscogee—Active—PA	Medical Center, Col. Path. Grp. Columbus, Ga. 31902
LaBiche, Henry, Jr. Muscogee—Active—PA	Medical Center Columbus, Ga. 31902
MacNabb, George M. Coweta—Active—I	15 Cavender St. Newnan, Ga. 30263
Mahayni, Ahmad S. Ben Hill—Irwin—Active—SU	206 N. Main St. Fitzgerald, Ga. 31750
Peirce, Kenneth E. Muscogee—Active—AL	6655 Travis St. Houston, Texas 77025
Pilcher, James W. Jefferson—Active—IM	211 E. 7th St. Louisville, Ga. 30434
Prada, Oscar Muscogee—Active—FP	Louise Obici Memorial Hospital Suffolk, Va. 23434
Rosenberg, Raymond DeKalb—Active—PD	5 LaVista Perimeter Office Park Tucker, Ga. 30084
Tanner, Maurice B. Thomas Area—Active—R	113 W. Hansell St. Thomasville, Ga. 31792
Teal, Charles B., Jr. Hall—Associate—IM	Hall County Health Dept. Gainesville, Ga. 30501
Thames, Frank M., Jr. Habersham—Active—FP	Box 367 Demorest, Ga. 30535
Tippins, William C., Jr. DeKalb—Active—OBG	3290 Memorial Dr. Decatur, Ga. 30030
Vasko, Truman L. Flint—Active—SU	P.O. Box 247 Vienna, Ga. 31092
Windham, Addis D. Habersham—Active—FP	Box 367 Demorest, Ga. 30535

SOCIETIES

Fenwick T. Nichols, Jr. was installed as the **Georgia Medical Society's** new president at the Society's December meeting, and Thomas R. Freeman was chosen as president-elect. Other officers elected at the annual meeting include O. Emerson Ham, Jr., vice president; J. Robert Logan, secretary; Dearing A. Nash, treasurer.

DeKalb County Medical Society was addressed by Congressman Ben Blackburn January 21 at its monthly meeting. Benjamin B. Okel has been elected president of the Society for 1974, succeeding John P. Heard. Lawrence L. Freedman will serve as president-elect, LaMar S. McGinnis as vice president, Stanley P. Aldridge as secretary-treasurer, and Clyde B. Rountree and Charles W. McDowell as junior trustees.

The nominating committee of **South Georgia Medical Society** has recommended Robert Quattlebaum as 1974 president of the Society, Joe C. Stubbs as vice president and Jose Campa as secretary-treasurer. Speaker at the last quarterly meeting of the society for 1973 was Dr. James Talbert, University of Florida professor, who discussed acute surgical emergencies in the neonate.

New officers have been selected for the **Walker-Catoosa-Dade Counties Medical Society** for 1974: John P. Hoover, president; Ted D. Cash, president-elect; Murphy Cureton, secretary-treasurer; Ted D. Cash as delegate to MAG, and Ralph R. Greene as alternate delegate, both terms to expire in 1976. These officers were installed at the January 29 meeting of the Society.

PERSONALS

First District

Statesboro physician **Robert H. Swint** has been named official team physician at Georgia Southern College after several years of service in an unofficial capacity with the school's athletic program. Dr. Swint is an Emory graduate who has practiced in Statesboro since 1954.

Third District

A. Gatewood Dudley has returned to a practice of gynecology and obstetrics in Americus following a year

of study at Emory as a recipient of a grant from the National Cancer Institute.

New chief of staff of the Americus and Sumter County Medical Staff for 1974 is **Harvey L. Simpson** of Americus. **James C. Dudley** will serve as vice chief of staff and **Frederick H. Thompson** as secretary-treasurer.

Fourth District

Philip E. Christopher, Decatur, was presented the 1973 Julius A. McCurdy Citizenship Award at the December meeting of the DeKalb County Medical Society. This first recipient of the award in recognition of community service is involved in YMCA, school and community activities, in addition to the American Cancer Society and American Heart Association.

Outgoing DeKalb County president **John P. Heard** has announced his candidacy for a position on the AMA Board of Trustees, a position which will be filled at the AMA House of Delegates annual meeting in June.

Fifth District

J. Rhodes Haverty, dean of the School of Allied Health Sciences of Georgia State University, was one of the speakers at a training institute for educators in the allied health professions at Emory University in January.

Several Atlanta members have articles published in the January issue of the *Southern Medical Journal:* Charles B. Fulghum, Jr., "When Drinking Is a Pleasure," and Peter N. Symbas and C. R. Hatcher, Jr., two of four authors of "Purulent Pericarditis: A Review of Diagnostic and Surgical Principles."

Sixth District

Charlotte Cox, Macon, has passed the obstetrics-gynecology board exams and is now board certified.

Paul Reith has been named chief of staff at the Georgia Warm Springs Foundation, which has been reorganized recently for hospitalization and rehabilitation of severely disabled patients under the Department of Human Resources.

Macon physician **Robert Donner** was presented the Distinguished Community Service Award in December for his role in developing community drug services in the Middle Georgia area. He was also selected WMAZ's "Somebody Special" the week of December 10, 1973.

Seventh District

R. D. Walter, Calhoun, has been reappointed as chairman of the Mead Johnson Awards Committee for the American Academy of Family Physicians.

Eighth District

Douglas radiologist **Richard Benson** is one of 40 members of the United States Masters International Track Team which toured the South Pacific with a series of meets in December and January. The former Mercer University track star and holder of the school's mile record (4.35) qualified for the team on his proficiency and meeting the age requirement of being at least 40 years old. Dr. Benson is also a competing water skier and licensed pilot.

New member of the American Academy of Family Physicians is **John W. Herndon,** M.D., Douglas.

Tenth District

Augusta's **William Lotterhos** has been appointed to the American Academy of Family Physicians ad hoc committee to study the office of the president.

DEATHS

John Duval Campbell

Retired Atlanta psychiatrist John Duvall Campbell, 70, died October 31. The Dallas, Texas native was graduated from Southern Methodist University and Baylor Medical College. He practiced in Texas and Oklahoma, served with the Navy during World War II, and came to Atlanta in 1946.

Survivors include his widow, Mrs. Elise Smith Campbell; daughter, Mrs. Sara Kate Spell of Memphis, Tenn.; and brothers, Charles E. Campbell of Dallas and Thomas K. Campbell of Fort Worth, Texas.

The Month in Washington

Little noticed amid congressional confusion in attempting to deal with the energy crisis was the passage of a major health bill shortly before adjournment. The bill provides $375 million over five years to support the development of Health Maintenance Organizations (HMO's) across the country.

If signed into law by the President, the HMO legislation will go far in determining both consumer and provider acceptance of prepaid group health care. Despite a substantial flow of federal dollars into the experimental program, HMO's are not expected to encounter easy sailing. Ardent supporters of the program admit the trial period will be a rough one and caution against over optimism.

The speculation is that the President will sign the bill inasmuch as the money provided is not far over what the Administration originally requested, though the bill is much broader in scope than the President wished.

Two key provisions of the $805 million bill first approved by the Senate earlier this year were deleted or watered-down in conference enough to make the measure more palatable to the administration. One would have authorized federal subsidization of HMO premium costs for people who couldn't afford all or part of the cost. The other controversial Senate section would have created an independent Commission on Quality Health Care Assurance to supervise the HMO program. The

compromise bill vests this responsibility with the Assistant Secretary of HEW for Health.

Standards for HMOs

To qualify for federal aid, HMO's must meet a long list of federal standards of minimum benefits, stay open 24 hours a day, provide open enrollment, and conform to numerous other requirements. Inducements are provided to attract people from poor and rural areas.

The Senate provision authorizing grants to assist HMO's in meeting operating deficits during the initial three years of operation was knocked out of the final bill, but a loan fund was retained to aid HMO's in meeting "a portion of initial operating costs in excess of gross revenues."

Co-payments were barred under the Senate bill. However the conference agreed to allow HMO's to charge nominal co-payments, but not to the extent they could be considered a barrier to seeking treatment. The conference committee said the co-payments are aimed at enabling an HMO "to market its benefit package at a competitive price."

The final bill requires larger employers to offer workers an HMO option when existing contracts for health insurance expire provided that a qualified HMO is operating in the area.

The bill does not provide a specific number of HMO's, but the bill's legislative history indicates the Congress had in mind around 100 programs.

Legislator Seeks PSRO Repeal

Rep. John Rarick (D., La.), principal congressional sponsor of legislation to repeal the Professional Standards Review Organization (PSRO) program, has dispatched a letter to all members of the House urging their support.

In his letter, Rarick said PSRO "is the hottest controversy facing medical doctors and their patients. The American Medical Association's prestigious House of Delegates yesterday voted to seek congressional repeal of this controversial peer-review law that goes into effect on 1 January 1974."

Rarick quoted AMA President-elect Malcolm C. Todd, M.D., as calling PSRO ". . . The greatest threat to the private practice of medicine of any piece of legislation ever passed by congress."

The PSRO section of Medicare was added by the Senate and was never adequately debated, the lawmaker said. "The House did not even hold public hearings on this issue."

Rarick cited the *Wall Street Journal's* statement on PSRO—that points out that "the controversial legislation is laced with pointed references to 'new obligations imposed on' medical practitioners. It requires physicians to open their private files and hospital records to outside inspectors. Strong financial sanctions are provided for physicians who fail to comply."

Rarick wrote that he is concerned over the effect of the legislation on private medical practice in this country. "I am convinced that the medical profession has done an outstanding job of policing its own profession and establishing a high code of ethics. It simply does not make sense to bog down the medical profession with further government intervention that threatens the relationship between doctor and patient."

NHI Hearings

The first round of congressional hearings on National Health Insurance (NHI) concluded following a week of testimony from experts in the health-economic field who laid a general philosophical foundation for full-scale legislative sessions early in the new year.

The hearings by the House Health Subcommittee were the opening gun in what promises to be a busy 1974 in congress on the issue of a NHI bill.

The Subcommittee, headed by Rep. Paul Rogers (D., Fla.), has charted six weeks of further testimony in January and February that will consider specific legislative proposals. The House Ways and Means Committee also is slated to explore NHI sometime next year. Senate sessions are expected to open during the winter or spring by both Senate Finance and Senate Labor and Public Welfare Committees.

The next major development in the field will be the formal disclosure of the details of the Administration's new plan, expected to be unveiled in President Nixon's January State of the Union speech to congress and probably in a special message to congress on health.

The new Administration plan will be more liberal than the previous one, but it will continue to be based on the principle of requiring employers to furnish comprehensive health insurance to their workers. The major changes are a broad catastrophic provision tied to income and federal subsidization of premiums for all poor people. Medicare and Medicaid, apparently would lose their separate identities and become part of the new program under the jurisdiction of the Public Health Service.

According to Budget Director Roy Ash, NHI should be kept to a size that will avoid creating more demands for health services than can be met with existing resources. Otherwise, he said in an interview with the *New York Times,* there is a danger that the sole accomplishment would be an increase in the prices of health services.

Divergent Opinions

Many of the witnesses before Roger's Subcommittee predicted that a financing mechanism for NHI without other provisions would add to inflation of health care costs without much impact, if any, on the health of Americans. Other experts questioned whether any type of NHI would improve health, contending that environment, life styles, poverty, etc., are to blame for poor health conditions.

The closest approach to a consensus was that too much hope should not be placed in a NHI program to solve the health care problems of the nation.

One of the final witnesses, Robert J. Myers, former Chief Actuary of the Social Security Administration, denied there has been any crisis in health care costs, asserting that health has simply been caught up in the "general price and wage inflation resulting from the Viet Nam war, plus the more rapid wage increases of hospital personnel . . . plus the historical trend of medical care costs rising more rapidly than the general price level. . . ."

Myers said there is "far too much" first dollar coverage in private health insurance and not enough catastrophic coverage. Catastrophic, he said, "is sorely

needed by most Americans" and should vary with income and assets.

"I am convinced that cost-sharing provisions, properly designed can have a beneficial effect in preventing over-utilization without being an unjust economic barrier that will result in preventing the insured from receiving necessary medical care. . . ."

Under a sweeping NHI such as proposed by Sen. Edward Kennedy (D., Mass.), and labor "the providers of services might rebel if the financial screws on them are tightened too rapidly or too much, or the beneficiaries might rebel if they are regimented or controlled too much as to their desires for medical services," Myers told the subcommittee.

Herbert Denenberg, Pennsylvania Commissioner of Insurance, asked for strict cost and quality controls in any NHI program. "Pumping more dollars into a health care system with serious structural shortcomings will aggravate present problems."

Earl Brian, M.D., California Secretary of Health, stressed that the cooperation of organized medicine and other health providers is necessary for a NHI program to work. Otherwise, the nation's health care system will deterioriate, he said. As many responsibilities as possible should be left to the providers, according to Dr. Brian. He cited the cooperation of organized health groups in California despite state controls that have "alienated the health care community." The demand for medical care will always exceed the dollars available, he said, so any program must contain restrictions which relate it to the free market system. The present concern over Professional Standards Review Organizations is only a harbinger of what would happen if a bureaucratic NHI were enacted and demonstrates the "imprudence of permanent government controls," he asserted.

Cost-Saving Drug Plan

Sen. Edward Kennedy's Health Subcommittee hearings on the drug industry lived up to their explosive expectations with HEW Secretary Casper Weinberger throwing the first bomb by announcing that the Administration would propose a cost-saving drug plan for Medicare and Medicaid patients under which reimbursement would be limited to "the lowest cost at which the drug is generally available."

Estimating the savings at from $25 to $60 millions a year, the HEW proposal was a blow to the pharmaceutical industry which viewed it as a step toward generic prescribing and a set back to the brand name concept. Congress would have to approve the proposal, however.

Under questioning from subcommittee members, Weinberger was vague about how the program would work, but emphasized that physicians would remain free to prescribe as they choose. Sen. Kennedy praised the proposal. Sen. Gaylord Nelson (D., Wis.) said the HEW recommendation "must be only the first step in

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a massive intrusion by the federal government into the prescribing habits of physicians."

The first day's session featured charges that drug companies are monopolistic, keep prices jacked high, and spend huge amounts on advertising. Physicians were described as inept and too generous prescribers of drugs influenced inordinately by advertising and drug detail men. It was implied that 100 deaths a day due to adverse drug reactions were the fault of the drug industry and the prescribing physicians.

Sen. Gaylord Nelson (D., Wis.), a subcommittee member, urged that prescription drug advertising be banned and trade names eliminated. Consumer advocate Ralph Nader agreed and recommended patent restriction.

In an opening statement, Kennedy said the hearings are designed to "search for legislative solutions to the problems surrounding the way drugs are developed, marketed and used in this country." He said "Too many physicians are prescribing too many drugs on the basis of too little information . . . such irrational prescribing is a product of physician ignorance, not malice. . . ."

Kennedy's subcommittee had never before asserted broad jurisdiction in the drug field. The hearings were viewed as a stake-out to this aspect of health and government, and also as a blow to Nelson who has been investigating the drug industry for years and is its strongest critic on Capitol Hill. Nelson is a new member of the Kennedy subcommittee. His previous forum was a Senate small business subcommittee.

AMA Spokesman

James H. Sammons, M.D., Chairman of the Board of the American Medical Association, told the subcommittee that in the heat of controversy it should be emphasized that "Today there are a large number of drug preparations available through a complex delivery system replete with checks and balances provided by industry, the Food and Drug Administration, physicians, pharmacists, and in some instances allied health personnel."

Dr. Sammons continued, "It is not surprising that this complex and important system carries with it complex problems that different groups within the system perceive differently . . . simple solutions for the management of our problems are not realistic."

The AMA official said the reduction in funding for research investigators could have an adverse effect on development of improved drugs. The complexity of FDA procedures "is becoming self-defeating and some new approaches are required if we are to be able to provide new and useful therapeutic agents to alleviate existing maladies."

What ever is done, Dr. Sammons said, "the physician must be able to prescribe the drug in dosage and strength deemed appropriate for his patient. . . ."

"Where appropriate, we believe the physician should prescribe the least expensive product," Dr. Sammons testified. "But the generic name on the bottle is not a

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guarantee of equivalence, nor for that matter does a generic prescription even guarantee to the patient that he will receive the least expensive product."

PMA Testifies

C. Joseph Stetler, President of the Pharmaceutical Manufacturers Association, testified that, "What the secretary is proposing represents an extraordinarily radical approach to health care, one which may give the appearance of providing first class medical care at less cost, but which will either require Medicare and Medicaid beneficiaries to accept inferior products or force them to pay the cost of first class medicines from their own household budgets."

Stetler said the proposal might have some merit if therapeutic equivalence of drugs could be assured, "but the published evidence is almost entirely on the other side. Reports of the clinical inequivalence of drugs sold under the same generic name are increasing as are quality control failures."

On another tact, Stetler said new drug discoveries have been a major contributor to improving health care, and that drug prices have held stable in a period of soaring inflation.

But, he warned, America is falling behind foreign competitors in the rate of pharmaceutical innovation, adding that the industry's pattern of discovery of new drugs and the stable prices of medicines are threatened by proposals to reduce incentives for drug producers to continue their massive research programs.

"Price setting, dilution of patent rights, or a government takeover of research and development or promotional activities," suggested by some, would be self-defeating and lead to higher prices and lower productivity, Stetler said.

Fuel Crisis

The Administration has moved to set clear fuel priorities in the health field as Congress was warned by health leaders that emergency care, drugs and devices and hospital care could be severely affected unless sufficient fuel is made available this winter.

Immediately following a hastily scheduled one-day hearing before the Senate Health Subcommittee, William E. Simon, head of the Federal Energy Office, said the pharmaceutical industry will get all the fuel it needs for production and research in order to maintain adequate supplies of essential drugs and medical supplies.

A spokesman for the American Medical Association testified there is a critical need to make special provisions for an adequate supply of motor fuel to meet the needs of medicine. J. Cuthbert Owens, M.D., a member of the AMA's Commission on Emergency Medical Services, said, "Physicians, nurses, life support personnel, rescue workers, and ambulances and other emergency motor vehicles must have a sufficient and continuous supply of gasoline to insure the provision of prompt care for the ill and injured. In addition, adequate fuel must be available to health care institutions, as well as to suppliers of necessary medical equipment and supplies." ■

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Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

WALLACE PHARMACEUTICALS
CRANBURY, NEW JERSEY 08512

Symposium '74—"The Struggle to Communicate"



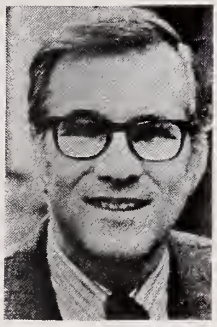
Buckley



Mead



Rusk



Robitscher



Malcolm



Sims

"Firing Line" host William F. Buckley, Jr., headlines the Ninth Annual multi-discipline symposium sponsored by the Cobb County Medical Society, which this year explores the topic, "The Struggle to Communicate."

The two-day event opens at Kennesaw Junior College in Marietta April 18 with Dr. Beverly T. Mead, chairman of the Department of Psychiatry of Creighton University School of Medicine in Omaha, Neb. His topic—"Must the Sexes Battle?" Sharing the program time will be groups and individuals demonstrating the use of music, poetry and dance in communication.

Friday, April 19 Dean Rusk will speak on the campus on "What Happens When Nations Say Hello?" Dr. Jonas Robitscher, Henry Luce Professor of Law and Behavioral Sciences of Emory University asks the question, "Can 'Professionals' Talk with Each Other?" The important problem, "Can We Close the Communication Gap Between Youth and the Adult Establishment?" will be explored by the Reverend Henry W. Malcolm, Maryland consultant and author in the field of behavior, alcoholism, etc.

A panel composed of these speakers will be moderated by the Rt. Reverend Bennett J. Sims, Episcopal Bishop of the Diocese of Atlanta at the conclusion of the morning's program. After lunch on the campus, group discussions between Symposium participants and the audience will be held.

William F. Buckley will be the dinner speaker at the Atlanta Marriott Motor Hotel at the closing session Friday evening. Mr. Buckley is the author of a dozen books and a syndicated newspaper column, host of a network television debate program, "Firing Line," and publisher of *National Review*. His topic will be "The Use and Abuse of the Media and Our Struggle to Communicate—Are the Media the Message?"

The Symposia is co-sponsored by the Cobb County Ministerial Association, the Cobb County Judicial Circuit Bar Association, and Kennesaw Junior College along with the Committee on Medicine and Religion of the Cobb County Medical Society. Information on registration may be obtained by contacting Symposium '74, Office of Community Relations, Kennesaw Junior College, Marietta, Ga. 30060, or by calling (404) 422-8770.

Medical Association of Georgia
Business Session

MAY 10-12, 1974—Savannah, Georgia

RESERVATION INFORMATION

1. Please complete this form and mail to: Reservation Department
   (Motel or hotel of your choice)
   Savannah, Georgia
2. Special reservation forms will be mailed by MAG Headquarters Office to officers, councilors and delegates for rooms at the DeSoto Hilton Hotel.
3. Assignment of rooms will be made in order of receipt of reservation by other hotels listed. If possible, confirmation will be in accordance with preference indicated; if not, best substitute will be made.
4. Unreserved accommodations will be released on April 20, 1974.
5. Rooms will not be ready for occupancy until 1:00 p.m. on day of arrival. Check-out time is 1:00 p.m. on your departure date.
6. Other members (not in categories named in (2)) may make reservations at below listed hotels if you desire to attend this Business Session.

DAILY HOTEL/MOTEL ROOM RATES—EUROPEAN PLAN (Meals not included)

Downtowner Motor Inn: 201 W. Oglethorpe Avenue (233-3531).
Single, $15; Twin/Double, $20.
Holiday Inn: 121 W. Boundary Street, on U. S. No. 17 at Talmadge Bridge (236-1355).
Single, $12; Double, $16; and Twin, $18.50.
Ramada Inn: 231 W. Boundary Street (232-1262).
Single, $14; Twin/Double, $18.

Cut out and send to motel/hotel of your choice:

Please type or print

Please reserve from block of rooms being held for:

MEDICAL ASSOCIATION OF GEORGIA

MAY 10-12, 1974

NAME .....

ADDRESS .....

CITY AND STATE ..... **ZIP** .....

ARRIVAL DATE ..... **DEPARTURE DATE** .....

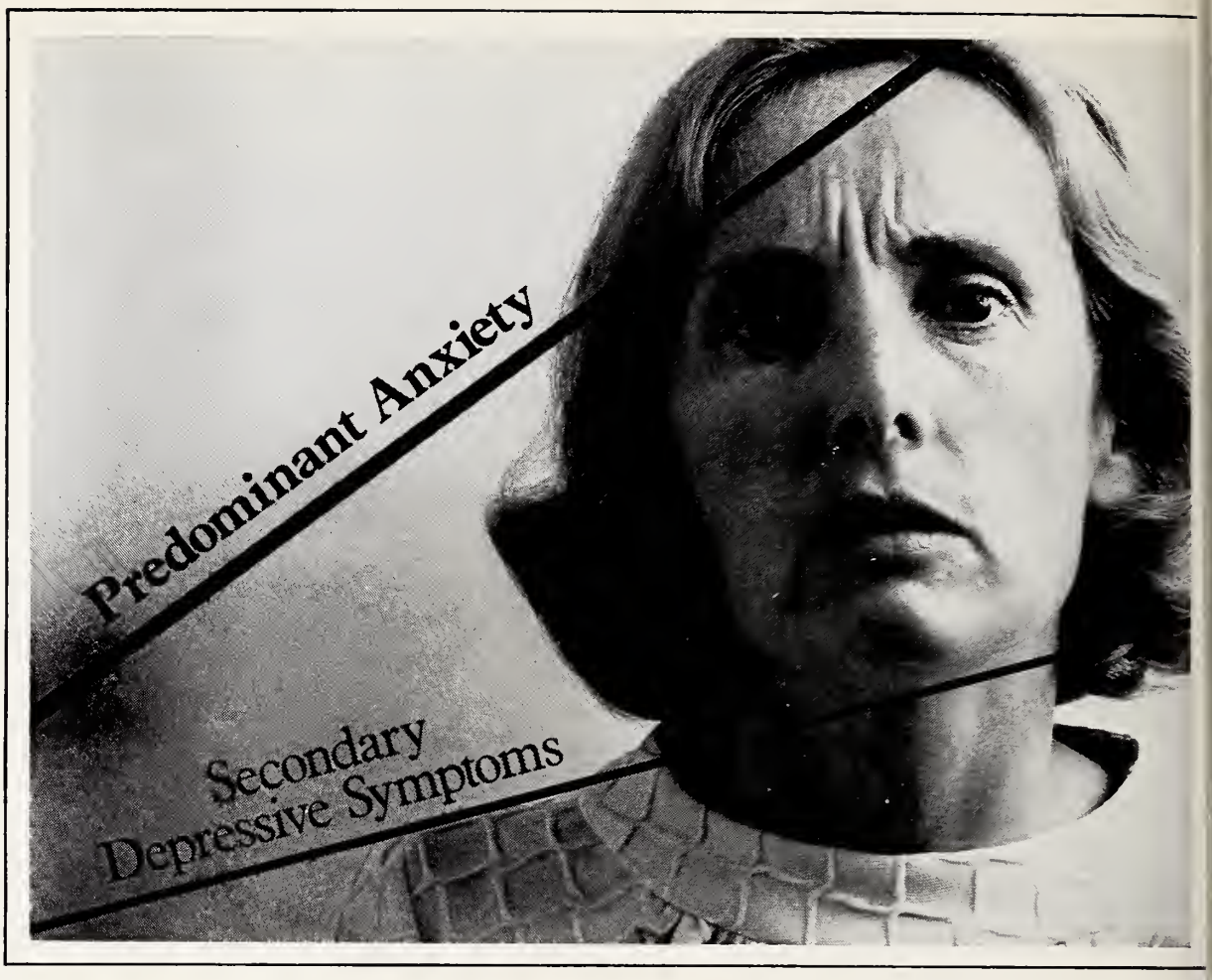
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19 Annual Session
Business Meeting

May 10-12, 1974/Savannah, Georgia



This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

JOURNAL
of the medical association of
georgia

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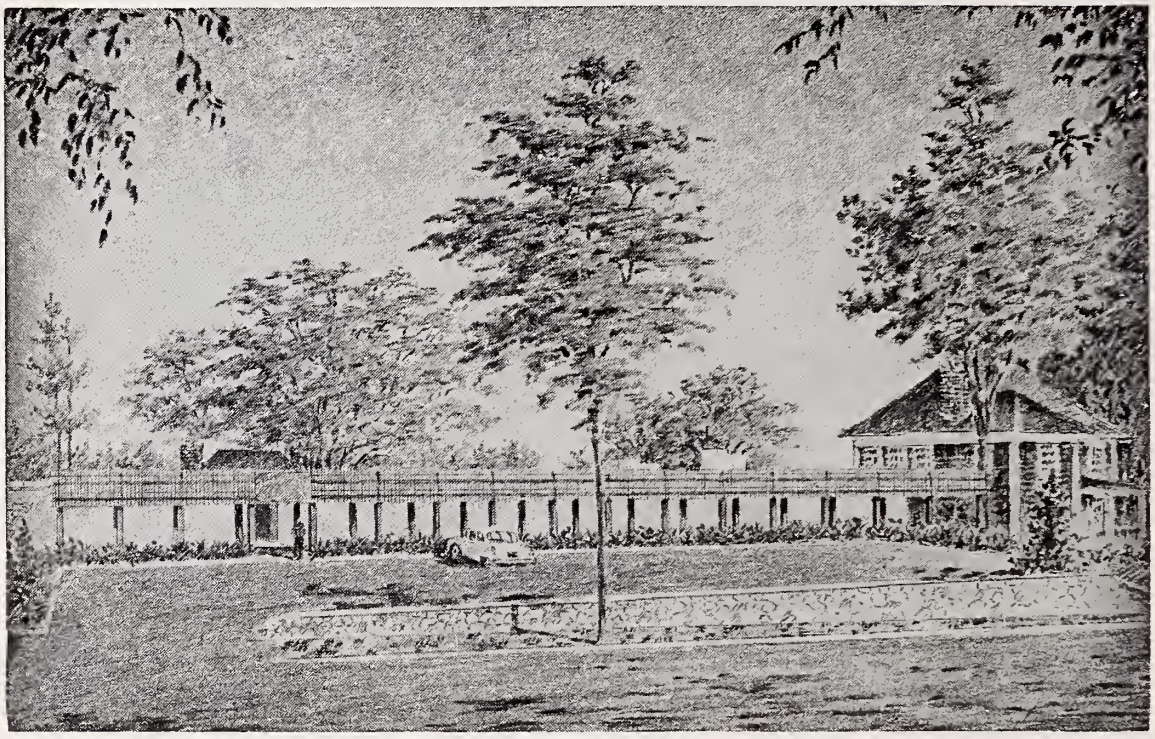
The charm of Savannah, host city for the 1974 Annual Session Business Meeting, is reflected in this photograph of the Forsyth Park Fountain by Ilhan Ermutlu, M.D., a former resident. The fountain dates from 1858 and is modeled after one at the London Exposition of 1844. Dr. Ermutlu now serves as the chief of the Village Pilot Project, Wm. S. Hall Psychiatric Institute, Columbia, S. C. Layout by Bob Hamill, Atlanta.

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METROPOLITAN PSYCHIATRIC CENTER, centrally located in downtown Atlanta, provides Comprehensive Psychiatric Care for adults and adolescent patients. In-patient Care, a Day Hospital Program, and Out-patient Care Programs are available at the Center. Alcohol and drug dependent patients are accepted.

The following modalities of treatment, diagnostic procedures, and ancillary services are utilized:

- Individual Psychotherapy
- Group Psychotherapy
- Somatic Therapy
- Family Counseling
- Psychological Testing
- Social Work Services
- Educational Tutoring
- Vocational Rehabilitation Counseling
- Consulting Staff—All Medical Specialties
- Full Laboratory Coverage—including EKG, EEG, and Brain Scan
- Full Radiology Services
- Activity Therapy Program including—Occupational Therapy and Recreational Therapy

The attending psychiatrist determines from the above comprehensive services available the most appropriate modality(s) of treatment but always within the theme of individualized care.

The Center provides 24 hour Psychiatric Emergency Coverage.

Additional information may be obtained by contacting the hospital by letter or telephone. **METROPOLITAN PSYCHIATRIC CENTER** is a member of the American Hospital Association, Georgia Hospital Association, National Association of Private Psychiatric Hospitals, and the Metropolitan Atlanta Hospital Council.

Official Call to Annual Session Business Meeting

Extended to All Officers, Councilors, Delegates and Interested Members Of the Medical Association of Georgia

THE FIRST BUSINESS MEETING of the Medical Association of Georgia's Annual Session will be convened in Savannah, May 10-12, 1974. In May 1973, the House of Delegates approved the division of the Annual Session into the Business and Scientific Meetings.

This Business Meeting will confine itself to the business affairs of the Association, a Memorial Service, an Awards Ceremony, elections of officers and an Installation Ceremony. There will also be an informational Georgia Medical Care Foundation, Medicare and Medicaid Workshop and a GaMPAC Brunch.

General Sessions

The opening session will be called to order by C. E. Bohler, M.D., Brooklet, president of the Medical Association of Georgia, at 9 a.m. on Friday, May 10, 1974, in the Ballroom of the DeSoto Hilton Hotel. There will be a report of the President of the Woman's Auxiliary to the Medical Association of Georgia and the President-Elect's Address will be the highlight of the morning.

Another General Session on Saturday, May 11, at noon, in the Ballroom of the DeSoto Hilton, will be devoted to the Memorial Service to honor the deceased members of the Medical Association of Georgia and the Woman's Auxiliary to the Medical Association of Georgia. Following this will be an Awards Ceremony at which time AMA-ERF checks will be presented to the two medical schools, 50 Year Membership Certificates, Life Membership Certificates, Certificates of Appreciation, Family Physician of the Year Award, Hardman Award, Civic Endeavor Award and the Distinguished Service Award will be made.

The final General Session will be held on Sunday, May 12, in the Ballroom of the DeSoto Hilton Hotel, immediately following the Second Session of the MAG House of Delegates. At this time there will be the installation of officers, the announcements of sites of the 1975 Business and Scientific Sessions and adjournment.

House of Delegates

The first session of the House of Delegates will convene on Friday, May 10, immediately following the Opening General Session, in the Ballroom of the DeSoto Hilton Hotel. At this time nominations of the MAG officers will be made, and reports of the officers and committees will be made. The second session of the House of Delegates will be convened on Sunday, May 12 in the same location at 9 a.m. for the hearing of Reference Committee reports. House actions and voting for MAG officers will take place during this session.

Reference Committees

Members are invited to appear before the Reference Committees of the House of Delegates on any business being considered by the House. The Reference Committees will meet from 1 p.m. to 5 p.m. on Friday, May 10, in assigned rooms at the DeSoto Hilton Hotel.

Memorial Service

The Association will hold the traditional Memorial Service at the General Session on Saturday, May 11, at noon in the DeSoto Hilton Hotel. A combined service will be held again this year with the Auxiliary, with the reading of the names of the deceased members of each of the organizations. This ceremony will honor and recall the service and contributions of those deceased members in the past year.

MAG Deceased Members

Harold W. Adams, Atlanta, Feb. 26, 1974
R. B. Ansley, Decatur, Nov. 1, 1973
C. F. Barnett, Atlanta, Nov. 3, 1973
Frank Bird, Lake Park, Nov. 28, 1973
Walter E. Brown, Savannah, March 12, 1974
John D. Campbell, Atlanta, Oct. 31, 1973

R. Carter Davis, Atlanta, May 6, 1973
George R. Dillinger, Thomasville, April 15, 1973
William L. Dobes, Atlanta, Feb. 9, 1974
Ira Goldberg, Augusta, April 29, 1973
Edward A. Gonzalez, Rome, Sept. 14, 1971
Eugene L. Griffin, Atlanta, Sept. 2, 1973
Thomas Harrold, Macon, May 29, 1973
Haywood N. Hill, Atlanta, Dec. 1, 1973
L. D. Hoppe, Atlanta, July 27, 1973
H. Walker Jernigan, Atlanta, Jan. 23, 1974
McClaren Johnson, Jr., Atlanta, Nov. 7, 1973
C. J. Maloy, Helena, Jan. 4, 1973
M. N. McCall, Jr., Acworth, Nov. 27, 1973
Joseph H. McCormick, Savannah, Feb. 21, 1974
W. W. Meriwether, Macon, June 12, 1973
John M. Miller, Augusta, April 23, 1972
F. C. Nesbit, Covington, May 10, 1973
Virgil W. Osborne, Decatur, Nov. 1, 1973
A. M. Phillips, Macon, April 9, 1973
C. E. Powell, Swainsboro, Feb. 12, 1973
C. M. Pugh, Lumpkin, Nov. 27, 1973
John H. Robbins, Athens, Dec. 14, 1973
Collis N. Tomblin, Columbus, May 13, 1973
Claude V. Vansant, Sr., Douglasville, Sept. 13, 1973
J. Frank Walker, Atlanta, Oct. 6, 1973
Bithel Wall, Americus, July 7, 1973
James B. Wilbanks, Clarkesville, Nov. 11, 1973
C. H. Willis, Jr., Augusta, Feb. 8, 1973
Herbert W. Wingate, Albany, July 22, 1973

Auxiliary Deceased Members

Mrs. Howard M. Coe ..... Brunswick
Mrs. Marshall Hall ..... Macon
Mrs. Charles C. Hinton ..... Macon
Mrs. Edwin C. Jungck ..... N. Augusta, S. C.
Mrs. J. C. Patterson ..... Cuthbert
Mrs. C. A. Rhodes ..... Atlanta
Mrs. Lewis Ridley, Jr. ..... Macon
Mrs. Charles O. Walker ..... Donalsonville

Awards

Physicians to be awarded Life Membership Cards and 50 Year Membership Certificates will be honored at the Awards Ceremony on Saturday, May 11, at noon in the DeSoto Hilton Hotel Ballroom.

Life Members

B. Russell Burke ..... Atlanta
W. Elizabeth Grambrell ..... Atlanta
Abraham Herman Germain ..... Jonesboro
John H. Jackson ..... Barnesville
Ruskin King ..... Savannah
J. G. McDaniel ..... Atlanta
W. M. Moncrief ..... Atlanta
R. P. Neville ..... Savannah
Robert L. Oliver ..... Savannah
Samuel W. Perry ..... Atlanta
W. L. Pomeroy ..... Waycross
Lewis L. Rawls ..... Macon
Walter P. Rhyne ..... Albany
Carter Smith, Sr. ..... Atlanta
John R. Walker ..... Atlanta

50 Year Members

Herbert Steed Alden ..... Atlanta
George H. Alexander ..... Forsyth
Henry J. Copeland ..... Griffin
Waldo E. Floyd ..... Statesboro
Robert C. McGahee ..... Augusta
Calvin B. Stewart ..... Atlanta
George A. Williams ..... Atlanta

The following awards will also be made at the General Session on May 11: AMA-ERF checks to the two medical schools, Certificates of Appreciation, Family Physician of the Year, the Hardman Award, the Civic Endeavor Award and the Distinguished Service Award.

President's Reception

The Association will honor its president at a reception to be held at 7 p.m., Saturday, May 11, in the Ballroom of the DeSoto Hilton Hotel.

GaMPAC Brunch

The Georgia Medical Political Action Committee will hold a brunch in the Ballroom of the DeSoto Hilton on Saturday, May 11, from 10 a.m. to noon. Tickets for this event will be on sale at the Registration Desk. An outstanding program has been arranged and a national political figure invited to speak. This brunch is open to all who are interested.

Alumni Events

The alumni receptions and dinners of the two Georgia medical schools, as well as other medical alumni class reunions can be held, if desired, during this Business Meeting. It has been suggested that these events would perhaps draw better attendance at the time of the Scientific Meetings to be held in the fall beginning in 1975. However, the Medical College of Georgia alumni have planned a reception and dinner Friday evening, May 10, in the Ballroom of the DeSoto Hilton Hotel.

Georgia Medical Care Foundation, Medicare and Medicaid Workshop

The necessity for scheduling an informational workshop at this session was approved by Council and has been scheduled for Friday, May 10, 1 p.m. to 5 p.m., in the South Ballroom of the DeSoto Hilton Hotel. There will be resource representatives

from each program to answer questions and hear any complaints from the membership.

Registration

A general registration desk for all will be open in the DeSoto Hilton Hotel on Friday, May 10, from 8 a.m. to 5 p.m. and on Saturday, May 11, from 8 a.m. to 5 p.m. On Sunday, May 12, the registration desk will be open from 8 a.m. to noon. Admission to meetings will be by registration badge only.

Council

The MAG Executive Committee of Council will meet at 10 a.m. Thursday, May 9, in the South Ballroom of the DeSoto Hilton Hotel. The Council meeting is scheduled for 2 p.m. in the same room. There will also be an Organizational Meeting of Council held following the adjournment of the Annual Session Business Meeting on Sunday, May 12, in the Ballroom.

Hotel Reservations

Officers, councilors, and delegates will be housed in a reserved block of rooms at the DeSoto Hilton Hotel. Special reservation forms will be issued to the above by the MAG Headquarters Office. The other motels holding rooms for this meeting are listed in the *JMAG*. Please request accommodations directly to the motel of your choice.

MAG Message Center

A Message Center will be maintained near the MAG Official Registration Desk for the convenience of the membership. Pages from the Auxiliary to the Medical Association of Georgia will staff this Message Center during the entire session for incoming messages only.

A bulletin board at this center will be available for notices of special importance and a paging system projector will be set up in the Ballroom during the General Sessions and the House of Delegates meetings.

MAG Headquarters Office

The Association staff will maintain a Headquarters Office in Suite 217-218 of the DeSoto Hilton Hotel.

Scientific Meetings

Every effort was made to develop the format and obtain cooperation and participation from a majority of the specialty societies comprising the Interspecialty Council so that the Scientific Meeting of the Annual Session could be held in 1974, but this was not achieved. A majority of the specialty societies did agree to participate in 1975 and with this in mind, plans are now being formulated to develop the program format for a two-day Session in October 1975. As soon as this is developed, information will be published in the *Journal*.

Specialty Society Activities

Some specialty societies have developed programs which coincide with 1974 Business Meeting. The Georgia Radiological Society will meet from 11 a.m. to 5 p.m., Saturday, May 11, in the South Ballroom, DeSoto Hilton Hotel. The Georgia Society of Plastic Surgeons will meet at 2 p.m., Saturday, May 11 in the Downtower Motor Hotel.

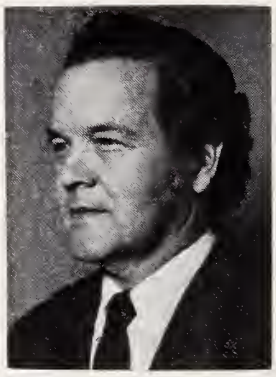
Leisure

In order for the membership to have some time during the Business Meeting to enjoy their own interests, particularly in a place like Savannah, Saturday afternoon, May 11, is open for whatever the members may desire.

1973-1974 MAG Officers and Council



C. E. Bohler
President



J. Rhodes Haverty
President-Elect



David A. Wells
Chairman of Council



H. Hilt Hammett
First Vice President



Luther M. Thomas, Jr.
Second Vice President



Earnest C. Atkins
Secretary



Carson B. Burgstiner
Treasurer

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President-Elect—J. Rhodes Haverty, Atlanta (1974)*
Immediate Past President—F. William Dowda, Atlanta (1976)*
Past President—W. C. Mitchell, Smyrna (1975)
Past President—F. G. Eldridge, Valdosta (1974)
First Vice President—H. Hilt Hammett, LaGrange (1974)*
Second Vice President—Luther M. Thomas, Jr., Augusta (1974)*
Chairman of Council—David A. Wells, Dalton (1974)*
Secretary—Earnest C. Atkins, Atlanta (1975)*
Treasurer—Carson B. Burgstiner, Savannah (1975)*
Speaker of the House—Harrison L. Rogers, Atlanta (1974)*
Vice Speaker of the House—L. C. Buchanan, Decatur (1974)*

* Executive Committee.

Chairman of Finance Committee—F. G. Eldridge, Valdosta (1974)*
Editor *JMAG*—Edgar Woody, Jr., Atlanta (1974)

Councilors

District:
1—Albert M. Deal, Statesboro (1976)
2—J. D. Bateman, Albany (1976)
3—John H. Robinson, Americus (1976)
6—W. E. Barron, Newnan (1974)
7—David A. Wells, Dalton (1974)
8—Robert E. Perry, Jr., Brunswick (1974)
9—Paul T. Scoggins, Commerce (1975)
10—Edwin W. Allen, Jr., Milledgeville (1975)
Bibb County Medical Society
Braswell E. Collins, Macon (1975)
Cobb County Medical Society
Remer Y. Clark, Marietta (1975)
DeKalb County Medical Society
L. C. Buchanan, Decatur (1975)
Medical Association of Atlanta
John T. Godwin, Atlanta (1974)
Fleming L. Jolley, Atlanta (1975)

J. Harold Harrison, Atlanta (1976)
Georgia Medical Society
L. R. Lanier, Jr., Savannah (1976)
Muscogee County Medical Society
Jack A. Raines, Columbus (1974)
Richmond County Medical Society
Ronald F. Galloway, Augusta (1975)

Vice Councilors

District:
1—Leon E. Curry, Metter (1976)
2—Frank R. Miller, Thomasville (1976)
3—B. Lamar Pilcher, Warner Robins (1976)
6—Norman P. Gardner, Thomaston (1974)
7—Don Schmidt, Cedartown (1974)
8—Joe C. Stubbs, Valdosta (1974)
9—Robert S. Tether, Gainesville (1975)
10—M. A. Hubert, Athens (1975)
Bibb County Medical Society
Milton I. Johnson, Macon (1975)
Cobb County Medical Society
Charles R. Underwood, Marietta (1975)
DeKalb County Medical Society
Luther M. Vinton, Avondale Estates (1975)
Medical Association of Atlanta
J. Norman Berry, Sandy Springs (1974)
T. J. Anderson, Jr., Atlanta (1975)
W. W. Moore, Jr., Atlanta (1976)
Georgia Medical Society
Irving Victor, Savannah (1976)
Muscogee County Medical Society
Louis A. Hazouri, Columbus (1974)
Richmond County Medical Society
Henry D. Scoggins, Augusta (1975)

Delegates to AMA as of January 1, 1974

Delegates	*Term Ending*
J. W. Chambers, LaGrange	(12-31-75)
John S. Atwater, Atlanta	(12-31-75)
(Position formerly held by J. Frank Walker, Atlanta)	(12-31-74)
Preston D. Ellington, Augusta	(12-31-74)
Alternate Delegates	*Term Ending*
F. G. Eldridge, Valdosta	(12-31-75)
Luther M. Vinton, Avondale Estates	(12-31-75)
J. D. Bateman, Albany	(12-31-74)
F. W. Dowda, Atlanta	(12-31-74)

Highlights of Executive Committee of Council

February 10, 1974

Appointments: Ad Hoc Committee on Laboratory Quality—Lester Forbes, M.D., Atlanta, chairman, Samuel Poole, M.D., Gainesville, Robert W. Oliver, M.D., Dublin, Waddell Barnes, M.D., Macon, Warren Gilbert, M.D., Rome, and Randolph Malone, M.D., Thomasville; Committee on Geriatric Medicine—Dan Burge, M.D., Atlanta; Committee on Private Practice—James L. Achord, M.D., Macon; Committee on Public Health—Stephen C. May, M.D., Kennesaw; Ad Hoc Committee on HMO—Charles R. Underwood, M.D., Marietta, chairman; additionally, all committee appointments for 1974-75 were made.

PSRO Repeal: Received report on encouraging contacts with Georgia's congressional delegation, contract for public relations assistance, plans for Medical Rally April 7 in Atlanta.

GMCF: Approved Foundation Bylaw changes for submission to Council.

EMCRO: Suggested meeting of Atlanta and Columbus Blues with representatives of EMCRO and MAG Executive Committee to discuss the EMCRO and CHIP hospital discharge abstract systems.

Medical Practice Act: Received report on progress of legislation to provide medical disciplinary procedures to State Composite Board of Medical Examiners.

Posting Fee Schedules: Referred for legal counsel opinion, new Cost of Living Council requirements on posting of sign regarding fees and availability of fee schedule on request issued pursuant to revised Federal Register regulations.

Official Program

Friday, May 10

8:00 GENERAL AND DELEGATES REGISTRATION
Ballroom Foyer, DeSoto Hilton Hotel

9:00 FIRST GENERAL SESSION
Ballroom, DeSoto Hilton Hotel
Presiding: C. E. Bohler, M.D., Brooklet, President, Medical Association of Georgia

Call to Order

Invocation

Introduction of Distinguished Guests

Report of the President of Woman's Auxiliary: Mrs. John G. Bates, Cuthbert, President, Woman's Auxiliary to the Medical Association of Georgia

Greetings from the President-Elect of the Woman's Auxiliary to the AMA: Mrs. Howard Liljestrand, Honolulu, Hawaii

President-Elect's Address: J. Rhodes Haverty, M.D., Atlanta

Announcements

Recess

10:00 FIRST SESSION, HOUSE OF DELEGATES
Ballroom, DeSoto Hilton Hotel
Presiding: Harrison L. Rogers, M.D., Atlanta, Speaker

Nominations of officers of MAG, AMA delegates and alternate delegates and report of councilor elections

Introduction of Business

Announcements

Recess

1:00 REFERENCE COMMITTEE MEETINGS
DeSoto Hilton Hotel

1:00 WORKSHOP ON GMCF, MEDICARE AND MEDICAID
South Ballroom, DeSoto Hilton Hotel

6:30 MEDICAL COLLEGE OF GEORGIA
Alumni reception and dinner
Ballroom, DeSoto Hilton Hotel

Saturday, May 11

8:00 GENERAL AND DELEGATES REGISTRATION
Ballroom Foyer, DeSoto Hilton Hotel

10:00 GaMPAC BRUNCH
Ballroom, DeSoto Hilton Hotel
(All physicians, Auxiliary members and guests invited)

Presiding: J. Daniel Bateman, M.D., Albany, Chairman

12:00 GENERAL SESSION
Ballroom, DeSoto Hilton Hotel
Presiding: C. E. Bohler, M.D., Brooklet, President, Medical Association of Georgia

Memorial Service

Presentation of Awards:
AMA-ERF Checks
Fifty Year Membership Certificates
Life Membership Certificates
Certificates of Appreciation
Family Physician of the Year Award
Hardman Award
Civic Endeavor Award
Distinguished Service Award

7:00 PRESIDENT'S RECEPTION
Ballroom, DeSoto Hilton Hotel
(All members, their wives and guests invited)

Sunday, May 12

8:00 GENERAL AND DELEGATES REGISTRATION
Ballroom Foyer, DeSoto Hilton Hotel

9:00 SECOND SESSION, HOUSE OF DELEGATES
Ballroom, DeSoto Hilton Hotel

Presiding: Harrison L. Rogers, M.D., Atlanta, Speaker

Election of MAG officers, AMA delegates and alternate delegates

Reference Committee Reports

Announcements

Adjournment of House of Delegates

12:00 FINAL GENERAL SESSION
Ballroom, DeSoto Hilton Hotel

(All physicians, Auxiliary members and guests invited)

Presiding: C. E. Bohler, M.D., Brooklet, President, Medical Association of Georgia

Installation of officers

Announcement of sites of 1975 Business and Scientific Sessions

Adjournment of Annual Session Business Meeting

Criteria for Selection of Recipients of MAG Awards

Hardman Cup

This award is presented for "the achievement of anyone who in the judgement of the Association has solved any outstanding problem in public health or made any discovery in medicine or surgery" or such contribution to the science of medicine. The recipient of this award will be selected by a five man secret committee. Nominations for this award are to be made by component county medical societies and all nominations must be accompanied by supporting biographical data and received at MAG Headquarters Office no later than two weeks prior to the opening of the Annual Session. If no nominations and supporting data are received, no award will be made. No nominations for this award may be made from the floor. If given, this award will be presented at the General Session, Saturday, May 11, at 12:00 noon. By custom this award has usually gone to a Georgia physician. However, this is not required by the terms of the letter from Governor Hardman establishing this award.

Distinguished Service

The Distinguished Service Award is presented for distinguished and meritorious service which reflects credit and honor on the Association. Nominations for this award should be made by component county medical societies and must be received at the MAG Headquarters office no later than two weeks prior to the opening of the Annual Session. They must be accompanied by biographical data supporting the nomination. The recipient will be selected by a five man secret committee and presentation will be made on Saturday, May 11, 12:00 noon, at a General Session.

Civic Endeavor Award

This award, presented for the first time at the 1969 Annual Session, will be given pursuant to an action taken by the 1968 House of Delegates, in Augusta. This award is to be given for outstanding public service and participation in civic activities. Component county medical societies are invited to make nominations for this award supported by appropriate data which must be received at the MAG Headquarters Office at least two weeks in advance of the Annual Session. The recipient of this award will be selected by a three man secret committee who shall determine if the nominees meet the requirements of the resolution which created this award. Presentation will be made at a General Session, Saturday, May 11, at 12:00 noon.

Certificates of Appreciation

Recipients of Certificates of Appreciation will be selected jointly by the MAG Committee on Awards, Executive Committee and Council. These will be presented on Saturday, May 11, at 12:00 noon, at a General Session.

Family Physician of the Year

(Formerly GP of the Year) This award is presented to an outstanding family physician in Georgia. Selection of the recipient is made by the Board of Directors of the Georgia Academy of Family Physicians and presentation of the award is made during the Annual Session. The name of the family physician accompanied by supporting biographical data was to be received at the MAG Headquarters Office by February 15. The President of the Georgia Academy of Family Physicians (or his designee in the event of his absence) will present this award at the General Session on May 11.

Medical Association of Georgia
Business Session

MAY 10-12, 1974—Savannah, Georgia

RESERVATION INFORMATION

1. Please complete this form and mail to: Reservation Department
   (Motel or hotel of your choice)
   Savannah, Georgia
2. Special reservation forms will be mailed by MAG Headquarters Office to officers, councilors and delegates for rooms at the DeSoto Hilton Hotel.
3. Assignment of rooms will be made in order of receipt of reservation by other hotels listed. If possible, confirmation will be in accordance with preference indicated; if not, best substitute will be made.
4. Unreserved accommodations will be released on April 20, 1974.
5. Rooms will not be ready for occupancy until 1:00 p.m. on day of arrival. Check-out time is 1:00 p.m. on your departure date.
6. Other members (not in categories named in (2)) may make reservations at below listed hotels if you desire to attend this Business Session.

DAILY HOTEL/MOTEL ROOM RATES—EUROPEAN PLAN (Meals not included)

Downtowner Motor Inn: 201 W. Oglethorpe Avenue (233-3531).
Single, $15; Twin/Double, $20.
Holiday Inn: 121 W. Boundary Street, on U. S. No. 17 at Talmadge Bridge (236-1355).
Single, $12; Double, $16; and Twin, $18.50.
Ramada Inn: 231 W. Boundary Street (232-1262).
Single, $14; Twin/Double, $18.

Cut out and send to motel/hotel of your choice:

Please type or print

Please reserve from block of rooms being held for:

MEDICAL ASSOCIATION OF GEORGIA

MAY 10-12, 1974

NAME .....

ADDRESS .....

CITY AND STATE ..... ZIP .....

ARRIVAL DATE ..... DEPARTURE DATE .....

TYPE OF ACCOMMODATIONS DESIRED ..... FOR ..... # OF PERSONS

WAMAG 49th Annual Convention

May 9-12, 1974 · DeSoto Hilton Hotel · Savannah, Georgia

President's Greeting



AS YOUR PRESIDENT, I am delighted to welcome each of you to our 49th Annual Convention of the Woman's Auxiliary to the Medical Association of Georgia.

Savannah, a city steeped in history and tradition, is very appropriate for the celebration of our 50th Anniversary and the founding of the Woman's Auxiliary to the Medical Association of Georgia. The members of the Woman's Auxiliary to the Georgia Medical Society have spent much time and effort to make this a memorable convention for each of you.

It is my sincere desire that together we will experience the joys of accomplishment and fellowship of the past year's activities of "Projecting Our Image."

Sincerely,
Mrs. John G. Bates, *President*
Woman's Auxiliary to the
Medical Association of Georgia

Welcome to Savannah



WELCOME TO SAVANNAH and the 50th Anniversary of the founding of the Woman's Auxiliary to the Medical Association of Georgia.

Mrs. Gene Tanner, our convention chairman, her assistant, Mrs. Rodney Hartmann, and Auxiliary members have many exciting things planned for you. Savannah has so much to offer, and we are pleased that again we have a chance to show her off.

Walking tours, riverfront activity, special Savannah food by Auxiliary members, 50 years of fashion, a tour of doctors' homes in the historic Savannah area are some of the activities offered. We hope you will come and participate in what we know will be a convention that is interesting and fun for all.

See you in May!

Mrs. Frank Carlton, *President*
Woman's Auxiliary to the
Georgia Medical Society

The Program

Thursday, May 9

2:00 to 5:00 REGISTRATION AND INFORMATION
Lobby, DeSoto Hilton Hotel

4:00 to 5:30 PRE-CONVENTION EXECUTIVE BOARD MEETING
James Madison Room, DeSoto Hilton Hotel
Presiding: Mrs. John G. Bates, Cuthbert, President, Woman's Auxiliary to the Medical Association of Georgia

Invocation: Mrs. Paul T. Scoggins, Commerce, State Historian

Pledge of Loyalty and Collect: Mrs. Robert P. Wight, Tifton, President, Tift County Medical Auxiliary

Introduction of Past President: Mrs. Hayward S. Phillips, Augusta, Past President

Adjournment

5:30 to SOCIAL HOUR
President's Suite, DeSoto Hilton Hotel

6:30 (For 1973-74 and 1974-75 county presidents, presidents-elect and state chairmen)
Presiding: Mrs. George Harrison, Marietta, President-Elect, WAMAG

Friday, May 10

8:30 to 5:00 **REGISTRATION AND INFORMATION HOSPITALITY, SHOW AND TELL EXHIBITS**
ARTS AND CRAFTS SHOW
Lobby, DeSoto Hilton Hotel

9:00 to 10:00 **MAG FIRST GENERAL SESSION AND HOUSE OF DELEGATES**
Ballroom, DeSoto Hilton Hotel
(All MAG and Auxiliary members and guests invited)
Presiding: C. E. Bohler, M.D., Brooklet, President, Medical Association of Georgia

Report of Woman's Auxiliary to the Medical Association of Georgia: Mrs. John G. Bates, Cuthbert, President

Greetings from the Woman's Auxiliary to the AMA: Mrs. Howard Liljestrand, Honolulu, Hawaii, President-Elect

10:30 to 12:30 **AUXILIARY GENERAL MEETING**
Pulaski Room, DeSoto Hilton Hotel
Call to Order: Mrs. John G. Bates, Cuthbert, President

Invocation: Mrs. Jack F. Menendez, Macon, President, Bibb County Medical Auxiliary

Pledge of Allegiance to Flag: Mrs. William T. Layne, Marietta, President, Cobb County Medical Auxiliary

Pledge of Loyalty and Collect: Mrs. J. Ruel McMillian, Rome, Seventh District Councilor and President, Floyd-Polk-Chattooga Medical Auxiliary

Address of Welcome: Mrs. Frank E. Carlton, Savannah, President, Woman's Auxiliary to the Georgia Medical Society

Response to Welcome: Mrs. George M. Callaway, Jr., Atlanta, President, Medical Association of Atlanta Auxiliary

Presentation of Convention Plans: Mrs. David E. Tanner, Savannah, Convention Chairman

Introduction of Pages for the Day: Mrs. John West, Savannah

Introduction of Past Presidents and Guests: Mrs. Louie H. Griffin, Sr., Claxton, Past President

Greetings: C. E. Bohler, M.D., Brooklet, President of MAG; and J. Rhodes Haverty, M.D., Atlanta, President-Elect

Introduction of Guest Speakers: Mrs. James H. Manning, Marietta, Past President, Council and President-Elect of Southern Medical Auxiliary

Address: Mrs. W. Nash Thompson, Stuart, Virginia, President, Woman's Auxiliary to the Southern Medical Association

Introduction of County Presidents: Mrs. George Harrison, Marietta, President-Elect WAMAG

Idea Exchange: County Presidents (all reports limited to two minutes)

Business Session: (all reports limited to two minutes)

Convention Rules of Order: Mrs. James H. Manning, Marietta, Parliamentarian and Past President

Roll Call and Minutes: Mrs. Robert M. Fine, Atlanta, Recording Secretary

Treasurer's Report (including auditor's report): Mrs. Murphy K. Cureton, LaFayette, Treasurer

Report of Advisory Committee to the WAMAG: Braswell E. Collins, M.D., Macon, Chairman

President's Report: Mrs. John G. Bates, Cuthbert

President-Elect's Report: Mrs. George Harrison, Marietta

Addendum Reports, State Officers and Chairmen (complete reports are published in the 1973-74 Annual Report)

Recommendations from the Executive Board: Mrs. Robert M. Fine, Atlanta, Recording Secretary

Report of Revisions Committee: Mrs. S. William Clark, Jr., Waycross, Chairman

Report of the Budget and Finance Committee: Mrs. C. James Roper, Jasper, Chairman

Report of the Resolutions Committee: Mrs. Harry B. O'Rear, Augusta, Chairman and Middle Georgia Area Vice-President

Report of the Credentials Committee: Mrs. Stuart Wallace, Savannah

Announcements

Recess

1:00 AWARDS LUNCHEON
Arcade, DeSoto Hilton Hotel
Honoring: Members-at-Large of the WAMAG

Presiding: Mrs. John G. Bates, Cuthbert, President

Invocation: Mrs. Cliff Moore, Jr., Rome, Past President and Achievement Awards Chairman

Introduction of Past Presidents and Guests: Mrs. Shelley C. Davis, Atlanta, Past President

Introduction of Guest Speaker: Mrs. George Harrison, Marietta, President-Elect

Address: Mrs. Howard Liljestrand, Honolulu, Hawaii, President-Elect, Woman's Auxiliary to the AMA

Report of Awards Committees:
Achievement Awards—Mrs. Neal F. Yeomans, Waycross, Chairman
AMA-ERF Awards—Mrs. Russell Andrews, Jr., Rome, Chairman
Marie S. Burns Safety Award—Mrs. Joseph L. Berg, Albany, Chairman
Mrs. James Bonner White Scrapbook Awards—Mrs. M. Freeman Simmons, Decatur, Chairman
James N. Brawner, Sr., M.D. Awards for Excellence—Mrs. Cliff Moore, Jr., Rome, Chairman
(Winners of awards will please remain after adjournment for official photographs)

SECOND GENERAL SESSION
Second Report of Bylaws and Revisions Committee: Mrs. S. William Clark, Jr., Waycross, Chairman

Historical Savannah: Mrs. Edward F. Downing, Savannah

Adjournment

2:30 to 5:30 TOUR OF RESTORED HOMES

4:00 to 5:30 TASTING TEA
St. John's Parish House
Honoring: Mrs. Howard Liljestrand, Hawaii, President-Elect Woman's Auxiliary to the AMA, and Mrs. W. Nash Thompson, Virginia, President, Woman's Auxiliary to the SMA

Saturday, May 11

8:30 PAST PRESIDENTS' BREAKFAST (DUTCH)
James Madison Room, DeSoto Hilton Hotel

8:30 to 5:00 REGISTRATION AND INFORMATION
HOSPITALITY, SHOW AND TELL EXHIBITS
ARTS AND CRAFTS SHOW
Lobby, DeSoto Hilton Hotel

10:00 to 12:00 GaMPAC BRUNCH
Ballroom, DeSoto Hilton Hotel

11:00 to 12:00 AUXILIARY GENERAL MEETING
Pulaski Room, DeSoto Hilton Hotel

12:00 to 1:00 MAG GENERAL SESSION
Ballroom, DeSoto Hilton Hotel
(All MAG, Auxiliary members and guests invited)

Memorial Service for MAG and WAMAG

Presentation of Awards

Adjournment

1:15 50TH ANNIVERSARY LUNCHEON MEETING AND FASHION SHOW
Arcade, DeSoto Hilton Hotel
Honoring: Past State Presidents of the WAMAG

Presiding: Mrs. John G. Bates, Cuthbert, President

Invocation: Mrs. Allan C. Batchelor, Bremen, President, Carroll-Douglas-Haralson Medical Auxiliary

Introduction of Past Presidents and Guests: Mrs. George W. Statham, Past President

Report of Nominating Committee: Mrs. Cliff Moore, Jr., Rome, Chairman

Election of Officers

Installation of Officers: Mrs. Howard Liljestrand, Hawaii, President-Elect, Woman's Auxiliary to the AMA

Inaugural Address and Announcements of 1973-74 State Chairman: Mrs. George Harrison, Marietta, President

Presentation of Past President's Pin: Mrs. Cliff Moore, Jr., Rome, Past President

Report of Courtesy Committee: Mrs. William E. McDavid, Jr., Jonesboro, Chairman

Report of Credentials Committee: Mrs. Stuart Wallace, Savannah

Observance of 50th Anniversary of the WAMAG

Announcements

Adjournment

3:00 to 5:00 POST-CONVENTION EXECUTIVE BOARD MEETING
Pulaski Room, DeSoto Hilton Hotel
Presiding: Mrs. George Harrison, Marietta, President

7:00 to 9:00 MAG PRESIDENT'S RECEPTION
Ballroom, DeSoto Hilton Hotel

Sunday, May 12

9:00 to 12:00 MAG HOUSE OF DELEGATES AND FINAL SESSION
Ballroom, DeSoto Hilton Hotel
(All Auxiliary members and guests invited)

Election and Installation of Officers

Woman's Auxiliary to the Medical Association of Georgia 1973-1974

Officers

President ..... Mrs. John G. Bates
515 Court Street, Cuthbert, Georgia 31740
President-Elect ..... Mrs. George Harrison
576 Pickett Road, S.W., Marietta, Georgia 30060
First Vice-President ..... Mrs. Benjamin Bashinski
445 Lamar Drive, Macon, Georgia 31704
Second Vice-President ..... Mrs. Earl T. McGhee
808 Atkinson Drive, Dalton, Georgia 30720
Third Vice-President ..... Mrs. William J. Pendergrast
3398 Briarcliff Road, N.E., Atlanta, Georgia 30345
Area Vice-Presidents:
North Georgia ..... Mrs. Phil C. Astin, Jr.
100 Remington Circle, Carrollton, Georgia 30117
Middle Georgia ..... Mrs. Harry B. O'Rear
3069 Hillsdale Drive, Augusta, Georgia 30904
South Georgia ..... Mrs. W. Jack Smith
4121 Riverside Drive, Brunswick, Georgia 31520
Recording Secretary ..... Mrs. Robert M. Fine
2025 Breckenridge Drive, N.E., Atlanta, Georgia 30345
Corresponding Secretary ..... Mrs. Charles M. Ward
P.O. Box 203, Dawson, Georgia 31742
Treasurer ..... Mrs. Murphy K. Cureton
6 Sunset Drive, LaFayette, Georgia 30728
Historian ..... Mrs. Paul T. Scoggins
222 Washington Avenue, Commerce, Georgia 30529
Parliamentarian ..... Mrs. James H. Manning
643 Kennesaw Avenue, N.W., Marietta, Georgia 30060

1973-74 STATE COMMITTEE CHAIRMEN

Auxiliary Activities Division

AMA-ERF ..... Mrs. Russell Andrews, Jr.
Route 8, Kingston Road, Rome, Georgia 30161
AMA-ERF (Co-chairman) ..... Mrs. Henry Scoggins
3107 Vassar Drive, Augusta, Georgia 30904
Health Manpower ..... Mrs. Leonard Brown
1050 Mountain Creek Trail, N.W., Atlanta, Georgia 30328
International Health ..... Mrs. Robert S. McMichael
753 Fair Oaks Drive, Macon, Georgia 31204
Legislation ..... Mrs. William J. Pendergrast
3398 Briarcliff Road, N.E., Atlanta, Georgia 30345

Community Activities Division

Health Education ..... Mrs. Milton F. Bryant
3569 Dumbarton Road, N.W., Atlanta, Georgia 30327
Mental Health ..... Mrs. Michael A. Glucksman
152 Fairway Oaks Drive, Brunswick, Georgia 31520
Aging and Homebound ..... Mrs. John M. Anderson
3844 Club Drive, N.E., Atlanta, Georgia 30319
Nutrition ..... Mrs. Carl Pittman, Jr.
415 W. 18th Street, Tifton, Georgia 31794
Ecology ..... Mrs. James H. Sullivan
2519 Craigston Drive, Columbus, Georgia 31906
Rural Health ..... Mrs. Emory W. Holloway, Jr.
180 Parkview Drive, Commerce, Georgia 30529

Health Services

Children and Youth ..... Mrs. Daniel H. G. Glover
2100 McDowell Street, Augusta, Georgia 30904
Safety ..... Mrs. Joseph L. Berg
1603 Lynwood Lane, Albany, Georgia 31705
Blood Donor ..... Mrs. Norman B. Pursley
3427 Old Savannah Road, Augusta, Georgia 30906

Awards Committees

Achievement Awards ..... Mrs. Neal F. Yeomans
AMA-ERF ..... Mrs. Russell Andrews, Jr.
Route 8, Kingston Road, Rome, Georgia 30161
James N. Brawner, Sr., M.D. Certificate of Excellence
..... Mrs. Cliff Moore, Jr.
115 Saddle Mountain Road, Rome, Georgia 30161
Scrapbook ..... Mrs. M. Freeman Simmons
301 Woodview Drive, Decatur, Georgia 30030
Marie S. Burns Safety Award ..... Mrs. Joseph L. Berg
1603 Lynwood Lane, Albany, Georgia 31705
Health Careers Awards ..... Mrs. Leonard Brown
1050 Mountain Creek Trail, N.W., Atlanta, Georgia 30328

Internal Affairs Committees

Archives ..... Mrs. Roy G. Duncan
509 Heyward Circle, N.W., Marietta, Georgia 30060
Budget and Finance ..... Mrs. C. James Roper
992 South Main Street, Jasper, Georgia 30143
Bylaws and Revisions ..... Mrs. S. William Clark, Jr.
1409 Satilla Boulevard, Waycross, Georgia 31501
Convention Co-Chairmen ..... Mrs. George Straight
205 Johnston Street, Savannah, Georgia 31405
..... Mrs. David E. Tanner
20 Tiffany Place, Savannah, Georgia 31406
Editorial (Pulse Line and Public Relations) .. Mrs. B. Donald Minor
2256 Sagamore Hills Drive, Decatur, Georgia 30033
Membership ..... Mrs. Benjamin Bashinski, Jr.
445 Lamar Drive, Macon, Georgia 31204
Philanthropy ..... Mrs. George W. Statham
The Paces, 148 Bocage Walk, N.W., Atlanta, Georgia 30305
Philanthropy (Co-chairmen) ..... Mrs. Hayward S. Phillips
1082 Bertram Road, Augusta, Georgia 30904
..... Mrs. Louie H. Griffin
P.O. Box 547, Claxton, Georgia 30417
Program ..... Mrs. Earl T. McGhee
808 Atkinson Drive, Dalton, Georgia 30720
Program Development ..... Mrs. George Harrison
576 Pickett Road, S.W., Marietta, Georgia 30060
William R. Dancy, M.D. Student Loan Fund
..... Mrs. William N. Agostas
2302 Overton Road, Augusta, Georgia 30904
Loan Fund Co-Chairmen ..... Mrs. Harry B. O'Rear
3069 Hillsdale Drive, Augusta, Georgia 30904
..... Mrs. Ronald F. Galloway
818 Windsor Court, Augusta, Georgia 30904

Southern Medical Auxiliary Activities

Councilor ..... MRS. JAMES HUNT MANNING
643 Kennesaw Avenue, N.W., Marietta, Georgia 30060
Doctor's Day ..... MRS. JACK MARION WALDREP
201 Greenview Road, Rome, Georgia 30161
Research and Romance of Medicine ... MRS. MILTON E. SATCHER, JR.
1171 West Paces Ferry Road, N.W., Atlanta, Georgia 30327

Ad Hoc Appointments

Executive Secretary ..... MRS. CATHERINE WOOTEN
938 Peachtree Street, N.E., Atlanta,Georgia 30309
GaMPAC Liaison ..... MRS. J. DANIEL BATEMAN
2105 Beattie Road, Albany, Georgia 31701
Reports Chairman ..... MRS. J. HAGAN BASKIN
2283 Sagamore Hills Drive, Decatur, Georgia 30033
WA-SAMA Liaison ..... MRS. HOWARD S. BROWN
5621 Ball Mill Road, Dunwoody, Georgia 30338

District Councilors

First District ..... MRS. FRED O. KESSLER, JR.
526 E. 53rd Street, Savannah, Georgia 31405
Second District ..... MRS. T. GRAY FOUNTAIN
4001 Old Dawson Road, Albany, Georgia 31701
Third District ..... MRS. ROBERT E. BARR
1410 24th Avenue, E., Cordele, Georgia 31015
Sixth District ..... MRS. JOE SAM ROBINSON
740 Pierce Avenue, Macon, Georgia 31204
Seventh District ..... MRS. J. RUEL MCMILLIAN
2 Beaver Run, Rome, Georgia 30161
Eighth District ..... MRS. JOSEPH RAYMOND MARTINEZ
701 City Boulevard, Waycross, Georgia 31501
Ninth District ..... MRS. FLETCHER O. GARRISON
Box 73, Demorest, Georgia 30535
Tenth District ..... MRS. ROBERT S. SPEARS
809 Kamel Circle, Augusta, Georgia 30904

Advisory Committee from the Medical Association Of Georgia

BRASWELL E. COLLINS, M.D., *Chairman*
800 First Street, Macon, Georgia 31201
JOHN G. BATES, M.D.
201 Randolph Street, Cuthbert, Georgia 31740
S.W. CLARK, JR., M.D.
P.O. Box 951, Waycross, Georgia 31501
F. W. DOWDA, M.D.
490 Peachtree Street, N.E., Atlanta, Georgia 30308
W. G. ELLIOTT, M.D.
201 Randolph Street, Cuthbert, Georgia 31740
GEORGE HARRISON, M.D.
1416 Cherokee Street, Marietta, Georgia 30062
MILTON I. JOHNSON, M.D.
2605 Cherokee Street, Macon, Georgia 31201
W. C. MITCHELL, M.D.
Mitchell Building, Sunset Street, Smyrna, Georgia 30080
CLIFF MOORE, JR., M.D.
304 E. 2nd Street, Rome, Georgia 30163
GEORGE W. STATHAM, M.D.
341 West Ponce de Leon Avenue, Decatur, Georgia 30030

The Medical Association of Georgia Related Committees

Cancer ..... Hoke Wammock, M.D., Chairman
Enoch Callaway Cancer Clinic, LaGrange, Georgia 30240
Communications ..... Robert P. Wight, M.D., Chairman
P.O. Box 1186, Tifton, Georgia 31794
Education ..... Nicholas E. Davies, M.D., Chairman
35 Collier Road, N.W., Atlanta, Georgia 30309
Legislation ..... (National, Unfilled)
Harrison L. Rogers, M.D., Chairman (State)
1293 Peachtree Street, N.E., Atlanta, Georgia 30309
Maternal and Infant Welfare ..... To Be Appointed
490 Peachtree Street, N.E., Atlanta, Georgia 30308
Mental Health ..... William S. Davis, M.D. Chairman
1970 Cliff Valley Way, N.E., Atlanta, Georgia 30329
Rural Health ..... Irving D. Hellenga, M.D., Chairman
Toccoa, Georgia 30577
School Child Health ..... Fred L. Allman, M.D., Chairman
33 North Avenue, N.E., Atlanta, Georgia 30308

Past Presidents and Conventions

Honorary Presidents for Life
Mrs. Eustace A. Allen, Atlanta
Mrs. Ralph H. Chaney, Augusta

1924—Augusta (Organization)—Mrs. C. W. Roberts, Atlanta (Deceased), Temporary Chairman
1925—Atlanta—Mrs. James N. Brawner, Sr., Atlanta (Deceased)
1926—Albany—Mrs. William H. Myers, Savannah
1927—Athens—Mrs. C. W. Roberts, Atlanta (Deceased)
1928—Savannah—Mrs. Paul Holiday (Mrs. J. C. Moore, Gaffney, S.C.)
1929—Macon—Mrs. Charles C. Hinton, Macon
1930—Augusta—Mrs. Marlon T. Benson, Atlanta (Deceased)
1931—Macon—Mrs. Charles C. Harrold, Macon (Deceased)
1932—Savannah—Mrs. Ralston Lattimore, Savannah
1933—Macon—Mrs. S. T. R. Revell, Louisville
1934—Augusta—Mrs. J. Bonar White, Atlanta (Deceased)
1935—Atlanta—Mrs. J. E. Penland, Waycross
1936—Savannah—Mrs. Ernest R. Harris, Winder (Deceased)
1937—Macon—Mrs. William R. Dancy, Savannah (Deceased)
1938—Augusta—Mrs. Ralph H. Chaney, Augusta
1939—Atlanta—Mrs. Warren A. Coleman, Eastman
1940—Savannah—Mrs. Eustace A. Allen, Atlanta
1941—Macon—Mrs. H. G. Bannister, Ila
1942—Augusta—Mrs. Lee Howard, Savannah
1943—Atlanta—Mrs. J. Lon King, Macon (Deceased)
1944—Savannah—Mrs. Olin S. Cofer, Atlanta
1945—No Convention
1946—Macon—Mrs. W. T. Randolph, Winder
1947—Augusta—Mrs. W. Bruce Schaefer, Toccoa
1948—Atlanta—Mrs. W. G. Elliott, Cuthbert
1949—Savannah—Mrs. S. A. Anderson, Atlanta
1950—Macon—Mrs. J. Harry Rogers, Atlanta
1951—Augusta—Mrs. Lehman W. Williams, Savannah
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Mrs. John West, Savannah

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Finance
Mrs. Marvin Skelton, Savannah

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Mrs. John Wade, Savannah
Mrs. Joseph Scarbrough, Savannah

Tour of Homes
Mrs. Rodney Hartmann, Savannah

Tasting Tea
Mrs. Joseph Morrison, Savannah

Past President's Breakfast
Mrs. Joseph Doolan, Savannah

Flowers for Memorial Service
Mrs. Robert Quattlebaum, Savannah

Saturday Luncheon
Mrs. Cliff Cannon, Savannah

50th Anniversary Fashion Show
Mrs. Joseph Edwards, Savannah
Mrs. Paul Buelvas, Savannah

President's Reception
Mrs. Moultrie Lee, Savannah
Mrs. Galen Huffman, Savannah

Rules to Govern the Convention

1. The voting body of the convention shall consist of the members of the Executive Board of the Woman's Auxiliary to the Medical Association of Georgia and the duly accredited delegates from the county auxiliaries. No one is entitled to vote until registered.
2. To gain recognition, a delegate is requested to rise, address the chair, give her name and the name of her auxiliary.
3. No delegate shall speak more than twice on the same subject, and is limited to two minutes each time.
4. Badges must be worn by members of the voting body during all general sessions of the convention.
5. Delegates' privileges are not transferable.
6. All motions shall be presented in writing to the Recording Secretary. They shall be signed by persons making and seconding the motion.
7. All original motions on resolutions shall be made by submitting two copies, one to the Resolution Committee and one to the Recording Secretary.
8. All persons appearing on the program must be seated near the platform when the session opens.

Whispering greatly retards the business of the meeting. Order must be maintained at all times. Please be prompt. Meetings will begin promptly at the time announced.

MAG Celebrates Its 125th Anniversary in Historic Savannah

THE JUXTAPOSITION OF NEW AND OLD will characterize MAG's May session this year. The year 1974 sees the introduction of a new format for the Business Session, now severed from the Scientific Session, and discussion will be heated on the forces that now tend to threaten the private practice of medicine. At the same time, graceful, history-conscious Savannah will conjure up unavoidable nostalgia as the Association celebrates the 125th anniversary of its founding. Appropriately, the 100th anniversary also was held in this coastal city whose own Georgia Medical Society is the oldest organized medical association in the state.

A colorful account of Georgia at the time MAG was founded was written in 1941 by Allen H. Bunch, M.D. of Atlanta who traced the history of the Association for the *Journal:*

"It was the year 1849. Queen Victoria ruled Britannia. 'Old Rough and Ready' Zachary Taylor sat in the White House. Winfield Scott had defeated Santa Ana in a series of bloody battles, captured Mexico City and acquired the territory now known as California, Utah and New Mexico. Gold had just been discovered in California and the tragic trek of the 100,000 'forty-niners' was at full tide. Webster, Clay, Calhoun, Stephen A. Douglas and Jefferson Davis were at the height of their heated debates in Washington. Morse's telegraph line had been completed recently between Washington and Baltimore. Crawford W. Long's discovery of the Anesthetic properties of ether was becoming widely used to the great relief of humanity.

"Georgia boasted of nearly 900,000 souls over half of whom were slaves. George W. Towns sat in Milledgeville as Governor. More railroad mileage existed in Georgia than in any other state of the Union, and the State had the greatest mileage in the world under one management. Savannah and Augusta were the oldest and largest centers of population, education and culture. Macon, the railroad center of the State, had a population of less than 5,000 nearly half of whom consisted of slaves. Atlanta was only a village, having just been established as Terminus in 1845.

"The *Southern Medical and Surgical Journal,* established at Augusta in 1839 by Dr. Milton Antony, carried the following suggestion in its February, 1849 issue, under the heading 'Medical Intelligence':

> 'To the Physicians of Georgia.—The Faculty of the Medical College of Georgia, suggest to the medical profession of the State, the propriety of organizing an association. Since the institution of the National or American Medical Association, our sister States, Alabama and South Carolina, have taken action on the subject. It is therefore proposed to call a convention of the physicians of Georgia, to be held in the City of Augusta, on Tuesday the 20th of February next, then to adopt such measures for the improvement and benefit of the profession as they may deem proper.
>
> 'The Georgia Rail Road has promptly reduced its fare to one-half, for all members of the profession coming to the convention, and it is presumed that the other rail roads will do the same.
>
> 'Editors favorable to the above object will please insert this notice'

"That the suggestion as to the place of meeting



Davenport House, home of Historic Savannah Foundation, Inc., on East State Street. Photographs by Ilhan M. Ermutlu, M.D.



Factors Walk (Bay Street) where Old Savannah's commercial agents met to exchange news. Unique buildings have three ground floor entrances.

of the proposed convention did not meet with unanimous approval is shown by the following notice which again appeared under the caption 'Medical Intelligence' in the March (1849) issue of the *Southern Medical and Surgical Journal:*

> *'The State Medical Convention.*—After the notice issued by the Faculty of the Medical College of Georgia, and published in our last No., for the physicians of the State to assemble in Augusta on the 20th of February, to organize a Medical Association, the Georgia Medical Society (of Savannah) made a suggestion for the meeting to be held in Macon on the 20th of March. This was soon followed by an article in one of the newspapers of Savannah, stating the change of place and time of the proposed convention of the physicians of the State.'

"Accordingly 75 physicians met in the Hall of the Tomichichi Division, Sons of Temperance, in Macon on the morning of March 20, 1849 'in pursuance of a call from the Medical College of the State of Georgia and the Georgia Medical Society of Savannah.' The convention was organized by the election of temporary officers and the 'appointment of a committee to draft a Constitution and By-Laws for the permanent organization of a State Medical Society. The convention then adjourned until 3 o'clock p.m.' "

In the April 1949 centennial issue of the *Journal,* additional history is provided in an editorial:

"The Medical Association of Georgia is 100 years old. Its organization meeting was held in Macon March 20, 1849.

"But organized medicine in Georgia began with the founding of the Georgia Medical Society (Chatham County) 145 years ago. A few more years and the Richmond County Medical Society was organized. Still later more county medical societies were started. The first effort directed towards the organization of a state medical association was the organization of the Central Medical Society, which held two or three meetings at Milledgeville. It has been said that this Central Medical Society failed for the reason all county medical societies then existent in Georgia were not invited to participate in the affairs of the organization.

"Finally, with the organization of what is known now as the Medical Association of Georgia, with 76 charter members, at the end of 50 years its members numbered 475. Its assets amounted to $160.09. Today its members number 2,202. Its assets cannot be valued in dollars and cents, though it can be said now that the Association is on a sound financial basis."

Current Trends in Historic Savannah

Savannahians and visitors are enjoying today the visible results of 20 years of preservation efforts. The 1,100 structures of historical and architectural importance within the Historic District are rapidly being renovated and adapted to contemporary uses. In the last five years Historic Savannah's $200,000 Revolving Fund alone has moved 42 buildings through the Foundation, representing acquisition costs of $756,793. In turn, these 42 units represent over a million dollars in restoration investment by private individuals.

It is recognized that all aspects of Savannah's Historic District are worthy of attention—not just isolated buildings but whole streetscapes are important. Therefore, careful attention has been paid to street and sidewalk paving, planting, and Savannah's 20 Green Squares—six of the squares are currently under urban renewal.

Current efforts are being made to extend the District into a Victorian area—a survey has just been completed identifying over 350 worthy buildings of

the 1870-1900 period which will be published in a forthcoming edition of Historic Savannah's architectural inventory.

Savannah's Bicentennial Project

The spectacular William Scarbrough House is being restored by Historic Savannah Foundation as its Bicentennial Project. The only unrestored house built by William Jay, architect in Savannah, this 1818 Regency mansion has been acclaimed by Frederick Doveton Nicholas, AIA, professor of architecture at the University of Virginia to represent "the height of Neoclassical design in America." The restoration of the house will spearhead an area reclamation within Savannah's National Historic District and create an active community facility for work relative to historic preservation, city planning, architectural and horticultural research. Historic Savannah Foundation will move its offices to the building and carry out its preservation program from the house.

Recommended Sites

In the Savannah Area Chamber of Commerce publication, "Touring Historic Savannah," the following museums and historical sites are recommended:

- Telfair Academy of Arts and Sciences, former home of the prominent Telfair family, containing important paintings, statuary and antique furnishings. Open Tuesday through Saturday, 10 a.m. to 5 p.m., Sunday 2 to 5 p.m.
- Davenport House, built in 1821-22 by Isaiah Davenport of English pottery family, fine example of Georgia architecture. Open Monday through Saturday 10 a.m. to 5 p.m., closed Sunday.
- Factors' Walk Military Museum in one of Savannah's most picturesque downtown areas, exhibits many authentic Civil War battlefield artifacts, edged



Telfair Academy of Arts and Sciences

weapon and uniform collection. Open daily 10 a.m. to 5 p.m., Sunday 2 to 5 p.m.

- Juliette Gordon Low Birthplace, first Registered National Historic Landmark for Savannah. Juliette Gordon Low founded Girl Scouts in the United States in 1912 in this city. Open weekdays, except Wednesday, 10 a.m. to 4 p.m., Sunday 2 to 4:40 p.m.
- Ships of the Sea Museum contains one of the most outstanding and comprehensive collections of ship models in the country, as well as collections of figureheads, scrimshaw work and other artifacts relating to the sea. Take a ride up the Savannah River on the Harbor Queen excursion boat docked outside the Museum. Open daily 10 a.m. to 6 p.m.

RECOMMENDED RESTAURANTS

Downtown area:

1. Boar's Head, 224 River Street, roast beef, steaks, dining by the Savannah River. Reservations needed.
2. Canton Restaurant, 134 Abercorn, good Chinese cooking.
3. DeSoto Hilton.
4. Crystal Beer Parlor, 301 W. Jones, good sandwiches, very casual.
5. The Exchange, 201 River Street, very good sandwiches, on the riverfront.
6. Hester's Martinique, South Jefferson Street, beef. Reservations needed.
7. Joe Hester's, 27 Barnard, good steaks and seafood. Reservations needed.
8. Mrs. Wilkes, Jones Street, great Southern cooking served family style with plenty to eat, no liquor.
9. The Pirate's House, 20 E. Broad.
10. The Pink House, 23 Abercorn, dining in an historic home. Reservations needed.

Further out:

11. Johnny Harris, 1651 Victory Drive, barbecue, steaks and roast beef.
12. Frank Paris Seafood, Tybee Road on left just over Thunderbolt Bridge, great seafood.
13. Tassey's Pier, River Road and Thunderbolt, dining on an inland waterway. Reservations.
14. Williams Seafood, Tybee Road, great seafood, no drinks served.

Poor diffusion of most antibiotics across the intact prostatic epithelium compounds the difficulty in treating chronic bacterial prostatitis.

Recurring Episodes of Prostatitis in the Young Male

DONALD J. MCKENZIE, M.D. *and* C. HUBERT HODGES, JR., M.D., *Thomasville**

IT IS THE GENERAL CONSENSUS today that bacterial prostatitis is the commonest cause of bladder infection in males with normal intravenous pyelograms. Probably one of the principal factors in the natural history of prostatitis is a strong tendency toward chronicity. In the male under age 50, significant hyperplasia of the prostate has probably not occurred, and the element of obstruction secondary to this is usually not a significant etiologic factor. To the busy practitioner, an episode of acute prostatitis in a young male may be regarded as a simple infection usually treated with complete symptomatic relief by analgesics and antibiotics. The dramatic clinical picture, ease of diagnosis, and response to antibiotic therapy make it easy to view acute bacterial prostatitis in terms of a short, self-limiting entity.

In reality, the pathogenesis of low-grade chronic prostatitis with periodic, highly symptomatic acute episodes may be occurring. Chronic bacterial prostatitis, however, is a subtle disease with small numbers of bacteria in the prostatic fluid. It may be impossible to diagnose on physical or cystoscopic examination and very difficult to eradicate with antibiotic therapy. It is fundamental to the principles of adequate therapy to appreciate the severe trauma sustained by the prostate gland in reacting to an acute infection.

Sections of prostate made during an acute episode reveal the fulminating nature of the infection and the subsequent necrosis and scarring down of prostatic tissue as the process is resolved. With each successive acute inflammatory process, the prostate gland probably becomes inherently less able to resist infection, and a tendency toward a chronic low-grade disease state becomes quite pronounced. A systematic approach to effective diagnosis and treatment achieves a high degree of importance not only in treating the acute process, but in preventing chronic processes with inevitable acute episodes from occurring.

Pathogenesis

Since prostatic tissue interfaces with blood vessels, lymphatics, and the urethra, it has been traditionally assumed that infections of the prostate represent direct extension from these surfaces. The literature is replete with references to distal foci of infections such as tooth abscesses, carbuncles, etc. as sights of origin for prostatitis. Since the majority of infectious organisms are in the coliform group, it has been further postulated that somehow these organisms are capable of extending to the prostate gland from their normal location in the intestinal tract.

In reviewing tissue sections of prostate with previous episodes of acute infection, the scarring and loculation of areas strongly suggest that the disease sequence may be acute infection, scarring, obstruction of prostatic ducts secondary to this, stasis, further infection and a consequent continuous recycling of the entire process.

Traditionally, bacterial invasion, by whatever route, has been assumed to be the causative agent. However, it is not unlikely that a viral etiology not only exists but may be a significant contributing agent in chronic prostatitis.

It has been postulated that the symptom complex of chronic prostatitis is primarily the result of prostatic congestion due to sexual inactivity in the previously sexually active male, and that these men should not be indiscriminately treated with antibiotics. There has been evidence presented that prostatic fluid itself exhibits antibacterial activity. How far this activity of the prostatic fluid prevents primary lodgement of bacteria in the prostate can not be stated with certainty, but prostatic fluid may have

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a role in preventing prostatic infections. Etiologic factors responsible for inflammation within the prostate may prove to be as numerous and diverse in nature as they are in many other parenchymal organs.

Any focus of infection elsewhere in the urinary tract may be a prime contributing factor toward chronic prostatitis. Although the etiologic factors may be quite numerous, it is important to consider some of the more common: (1) contracture of the bladder neck; (2) ureteral calculi, especially in the lower ureter; (3) distal urethral stricture.

Symptoms

Probably one of the primary symptoms of low grade infection of the prostate is pain. However, in reality, this is of little or questionable value as a diagnostic aid. Bors and Comarr[1] in their extensive research on the innervation of the bladder have amply demonstrated the diffuse nature of sensory pathways to the bladder neck and prostate. Undoubtedly, this accounts for the very wide differences in location of the pain patients with prostatitis describe. Actual urinary symptoms of frequency, dysuria and hesitancy vary depending on the current activity of the prostatic inflammatory process. If obstruction is present, however, the symptoms may persist even in periods of relative quiescence of the inflammatory process.

Multiple other symptoms have been observed in patients with chronic prostatitis including sporadic urethral discharge and sexual disturbances. Vague, ill defined perineal or rectal discomfort is a common complaint.

The symptomatology of low grade prostatitis is too ill defined and varied to be termed characteristic, and perhaps primarily for this reason symptoms are seldom the focal point in history, physical examination, and laboratory examination which point toward an infectious process in the prostate gland.

Diagnosis

Treatment of symptomatic relief of acute prostatitis with no further follow up is not adequate. Recurrent episodes of prostatitis may have a strong etiologic factor in inadequately treated acute prostatitis. For this reason, objective parameters gauging the infectious process achieve high degrees of importance. The following criteria for evaluating the status for the infectious process are presented:

1. Abnormal number of white cells in the prostatic secretion. This is generally considered to be over 15 white blood cells per high powered field.
2. Absence of normal prostatic secretory elements and substitution of these elements with leucocytes.
3. Positive culture growth of prostatic secretions.

Acute epididymo-orchitis may be the first clinical symptom of chronic infection of the prostate gland. Digital rectal examination of the prostate during relative quiescence of an infectious process may give little information. The small fibrotic gland of chronic prostatitis seldom yields secretion to aid in diagnosis. Examination of the seminal vesicle may reveal tenderness and enlargement indicative of an active infectious process in this area.

Examination of prostatic fluid microscopically and by culture although important is not specific. Histologic demonstration of foci of acute prostatitis in patients with semen white blood cell counts of less than 15 per milliliter and negative semen cultures is well documented. It has been postulated that with demonstrable histologic foci of acute prostatitis existing together with absence of usual clinical symptoms in bacteriologic documentation that a viral etiology may be quite significant in some cases.

Therapy

Once obstruction and distal foci of infection in the urinary tract have been ruled out, therapy should be based as much as possible on objective parameters. Since patients with acute prostatitis usually respond dramatically to antibacterial therapy, the primary concern with the treatment of prostatitis is quite naturally reduced to the management of the chronic state of this disease. Cultures of the urethra and prostatic secretions should be initiated and antibiotics selected by susceptibility testing of the pathogen. Even though the appropriate antibiotic is given in sufficient dosage to assure bactericidal levels of the drug in the plasma, antibiotics rarely cure chronic bacterial prostatitis. These patients show a persistence of the organism in prostatic fluid cultures, and it is the rule rather than the exception that infection of the bladder urine and recurrence of symptoms occur within a few days after drug withdrawal.

The various antibiotics useful in the treatment of gram negative pathogens do not diffuse across intact prostatic epithelium in sufficient concentrations to kill these organisms. Trimethoprin may be an exception to the above, but sufficient clinical experience is not available. It may be postulated that the dramatic response often seen in acute prostatitis may be due to the fact that the prostatic epithelium is not intact due to the intense acute inflammatory reaction, thus allowing diffusion of higher levels of antibiotics into the prostatic ducts. Long term "suppressive antibiotic therapy" seems to limit the chronic infection to the prostate rather than actually sterilizing the prostatic fluid. In this manner it is often possible to prevent infection of the bladder and accompanying symptoms.

Transurethral resection of infected prostatic tissue probably has a place in the treatment of chronic

prostatitis, but the poor results are well documented. The most encouraging statement one can make in favor of transurethral resection is that few patients are made worse by this treatment. Transurethral resection usually fails to remove the entire block of the infected tissue since portions of the infected tissue frequently are beyond the limits of normal resection.

Until agents or methods are available to allow sufficient concentrations of antibiotics in the prostatic fluid, it is unlikely that the treatment of chronic bacterial prostatitis will become simple or very effective.

REFERENCE

1. Bors, Ernest and Comarr, A. Estin: *Neurologic Urology;* Baltimore, Md., University Park Press, 1971, pp. 18-23, 77-99.

Family Practice Council Elects Officers at Second Annual Convention

The Georgia Council for Family Practice Education elected officers for 1974 at its second annual convention held recently in Macon.

Those selected include, as chairman, George R. Parkerson, Jr., M.D., director of the Department of Family Practice for the Medical Center of Central Georgia in Macon; as vice chairman, Wells T. Riley, M.D., chairman of the Education Committee of the Georgia Academy of Family Physicians, from Jonesboro; as secretary-treasurer, Jon Calvert, M.D., assistant professor in the Department of Family Practice at the Medical College of Georgia in Augusta.

Other family physicians on the Council include James L. Achord, M.D., the Medical Center of Central Georgia, Macon; Dan Cabaniss, M.D., The Medical Center, Columbus; Nicholas E. Davies, M.D., Medical Association of Georgia, Atlanta; Edwin Flournoy, M.D., Georgia Academy of Family Physicians, Albany; B. L. Hallman, M.D., Emory University, Atlanta; J. Rhodes Haverty, MAG representative, Atlanta; Kenneth E. Holtzapple, M.D., Martin Army Hospital, Fort Benning; William E. Lotterhos, M.D., Medical College of Georgia, Augusta; Frank A. Moorehead, M.D., U.S. Army Medical Center, Fort Gordon; John B. O'Neal, III, M.D., Elberton; Thomas A. Sappington, M.D., Thomaston; Nat B. Smith, M.D., Mercer Medical School, Macon; Howard Vigrass, M.D., The Medical Center, Columbus; Donald J. Welter, M.D., Georgia War Veterans Nursing Home, Augusta.

The Council for Family Practice Education was founded in Atlanta in the fall of 1973 to effect better cooperation and communication among family practice educators and their educational institutions, practicing physicians and the general public throughout the state.

The Council's primary goals for 1974 include developing programs that will help meet Georgia's needs for more qualified family physicians; coordinating research programs in family practice; and educating the public about the purposes of family practice.

Presently there are 27 physicians in Georgia's family practice residency programs. The Council is working intensively on ways to raise this number to meet Georgia's needs.

SEVERAL MEMBERS PASS FAMILY PRACTICE BOARD EXAMINATIONS

Seventeen MAG members are among those Georgia physicians announced to have passed examinations of the American Board of Family Practice given last October.

Those earning the title of Diplomate, ABFP, include: William C. Ford, Lavonia; Julio J. Hernandez, Baxley; Emory W. Holloway, Jr., Commerce; Charles W. Johns, Macon; T. Eugene Kennedy, Buford; William L. McDaniel, Jr., Dalton; D. R. Mahan, Jr., Dalton; David S. Mann, Macon; James E. Marlow, Dalton; Aldine M. Mays, Stockbridge; W. Lanier Nicholson, Hiawassee; Quentin Price, Dublin; Philip B. Sapp, Dalton; Robert W. Simmons, Dalton; O. Wytch Stubbs, Jr., Chamblee; Donald R. Thomas, Dalton; and David A. Wells, Dalton. MAG member Laurier E. Hackett of Springvale, Maine also has been named Diplomate.

Twelve Steps Toward Repeal

THE MAG HOUSE OF DELEGATES met in special session last December and voted to put MAG on record in opposition to the PSRO provisions of PL 92-603. Additionally, it directed that the Association commit itself to work for repeal of PSRO.

Based on the facts available to us we will oppose PSRO on the following grounds. The Department of HEW has stated that PSRO activities will curb rising medical costs. In our opinion the cost of medical care will drastically increase and manifest itself in increased Social Security taxes. A result of this will be that the overall health care system will note dramatic cost increases and physicians will be blamed for the failure of PSRO to accomplish the economic objectives. Confidentially between patients and physicians will be eliminated. A patient's chart will now be available to groups of doctors as well as bureaucratic laymen. This will spill over into the private sector as the government will have the right to review private patient claims and compare them with Medicare/Medicaid patients. Malpractice claims will increase because the standards that PSRO will establish will be used as the benchmark for deviation from good medical practice by a physician, thus indicating liability on his part. It is obvious that the quality of care may be decreased due to rationing of money when appropriated funds run low and that innovative medical care will be discouraged because new procedures or treatments will not be covered under the norms and standards established by PSRO.

Following the action of the House and on recommendation of the Executive Committee, the MAG Council adopted a plan which would guide us in our effort to persuade Congress to repeal this section of PL 92-603. Below is a skeleton outline of our repeal strategy. Concurrently with this plan we will be seeking other avenues of attack to reach our ultimate goal of repeal of this section of the law. Your efforts and input will be a vital part of our success in this program.

Battle Plan

1. We have retained outside public relations counsel to assist in the development of informational materials and to help conduct the media campaign necessary to success. PR counsel will also assist in the areas of Congressional contacts as well as with appropriate non-medical groups.

2. A special edition of the Journal of the MAG devoted to PSRO repeal will be issued in March. This special issue—the cover, editorials, articles, photographs, etc.—will deal exclusively with PSRO; what's wrong with it, why it should be repealed and how to do it.

3. An indispensable element in our campaign to seek repeal of PSRO is the support of your patients. To reach these people we will soon be mailing you a series of waiting room display "tent" cards explaining various bad effects of the PSRO law and soliciting their support of our position.

4. Seek passage of a resolution by the Georgia General Assembly urging Congress to repeal PSRO. THIS HAS BEEN ACCOMPLISHED.

5. It is obvious that if we are to achieve any degree of success that we must have the support of other state medical associations. Accordingly we have initiated a program to "lobby" other state associations to adopt a policy of repeal and in turn to work with the members of their congressional delegation seeking their support for PSRO repeal. Among other things, we will be sending to all state medical associations and to approximately 750 county medical societies an MAG Journal reprint of the report of the PSRO Committee published in the January issue of JMAG.

6. We plan to develop materials for use by medical leaders in talking with medical groups—county society, hospital staff, etc.—as well as for use in talking to civic groups and social groups.

7. We will work to inform the public generally. However, special emphasis will be placed on groups having a particular interest in the ramifications of PSRO. These would include such organizations as welfare rights groups, American Association of Retired People, National Retired Teachers Association and others.

8. A direct contact program is planned for all health related groups through professional associations of hospitals, nursing homes, osteopathic physicians, dentists, the medical schools, Blue Cross/Blue Shield and others.

9. On March 15, MAG will host a luncheon meeting in Washington for the members of the Georgia congressional delegation. This will be a part of our continuing discussion with our senators and representatives for the repeal of PSRO.

10. On April 7, we plan a one-day, all-day, all MAG member meeting in Atlanta with nationally recognized speakers to discuss PSRO repeal. We have in mind presenting a series of speakers who can address the problem from the standpoint of philosophy, tactics, etc., as well as assess the prospects for actually getting the law repealed and in what time frame this may be possible.

11. Very soon we expect to "kick off" a petition program in which we will attempt to get the personal signature of every physician member of every County Medical Society in Georgia on a petition resolution urging repeal of PSRO. Wide distribution of this will be made.

12. We anticipate a general intelligence gathering operation to form the basis on which future moves will be made. To gather the necessary information we will send three man teams to Washington on an irregular basis to discuss the matter with members of the Congress including chairmen of critical committees, and with selected people in the Executive branch.

The fight to repeal PSRO is going to be exceedingly difficult. It will require the best and most dedicated efforts of every member if it is to succeed. However, success is possible.

Foundation Review Procedures

THE GEORGIA MEDICAL CARE FOUNDATION, INC., is the peer review and medical audit branch of the Medical Association of Georgia. This issue of the JMAG finds the Foundation well into its fourth year of operation, and in the course of these four years, there have been many changes and refinements of the review procedures and mechanisms employed. In this article will be described the Foundation's current operating procedures.

While the Foundation is a separate corporation from the Medical Association of Georgia, it is governed by a Board of Directors that is nominated and elected by the Council of the Medical Association of Georgia, thus insuring a uniformity of purpose between the two organizations. Membership in the Foundation is, however, open to all physicians licensed to practice in the

State of Georgia, whether they are members of the Medical Association of Georgia or not, and now numbers nearly 1,700.

Promote and Develop

The purposes of the Foundation, as stated in its articles of incorporation, among others, are to promote and develop means whereby medical services of all kinds can be provided to the general public, at reasonable cost, and in accordance with proper medical and ethical standards; to study and promote improved methods and facilities for health care and the improvement of the public health; to promote the art and science of medicine and to foster medical education, and to disseminate information to the general public concerning science and health care.

To these ends, the principal function of the Georgia Medical Care Foundation is medical peer review, and this is carried out in a number of programs including hospital, physician, and nursing home review under the Medicaid program (Title XIX), and review of CHAMPUS, Blue Shield, and commercial health insurance claims. The purposes of this medical peer review are threefold: To determine the medical appropriateness of the services rendered; less frequently, to determine the reasonableness of the fees charged for a given service; and finally, and most important, the review offers an acceptable method of keeping medical providers up-dated in their field of practice as the result of review by their peers.

Current Review Process

In order to insure, in so far as is possible, a consistency in recommendations, the following review process is currently used in the review of all hospital and physician services:

(1) Claims received from either the Department of Human Resources, private insurance carriers, physicians, hospitals, or private patients for initial review are first surveyed for the completeness of the claim by clerical personnel. These claims are then reviewed by specially trained nurses, operating within guidelines developed through work with medical consultants and specialty panels, to determine whether the circumstances of the case seem to parallel any cases previously reviewed by the Foundation. If such is the case, and if there are no extenuating circumstances described in the medical records accompanying the claim, a recommendation is made based upon these previous parallel cases. The claim is then returned to the party requesting review. Other interested parties are also frequently notified of the findings.

(2) In claims where either the specifics of the case under consideration do not resemble previously reviewed cases, or where explanatory material is not enclosed with the medical records indicating the reasons for some unusual type of care, the claim is referred to a medical consultant for his determinations on the case. The medical consultants utilized are true peers of the physician under review, being for the most part, Board certified specialists in the same field of medicine as the physician under review and residing in the same, or similar, geographic areas within the state. Once the medical consultant makes his decision on a case, it is returned to the Foundation and the same notification process as previously cited takes place.

(3) Should a provider, a carrier, or a patient disagree with the recommendations of the Foundation upon initial review, appeals are considered and solicited if accompanied by additional medical information concerning the case. Such appeals, along with the complete medical record of the claim, are reviewed by the specialty panel representing the specialty of the physician under review. These panels are composed of specialists from around the State of Georgia, nominated by their specialty society and endorsed by the president of their MAG district, and meet every other month at the offices

of the Foundation to consider such appeals, as well as modifications of the guidelines employed by the initial review nurses. At the present time there are more than a dozen specialty panels active, involving 160 physicians and podiatrists, and several more are in process of formation at this time. After the specialty panel has reached its decision on a given claim, its findings are conveyed, in writing, to all concerned parties.

(4) Appeals above the specialty panel level may be considered by the Board of Directors of the Foundation and, if it is felt appropriate, referred to the Peer Review Committee of the Medical Association of Georgia for further consideration and review.

As noted, the review and appeal processes may be initiated by a provider, a carrier, or a patient, and the same review process standards are applied in all cases. Any persons or organizations having information concerning a claim under consideration, or wishing to initiate a review or an appeal of the findings with regard to a given case may do so by writing to the Georgia Medical Care Foundation. A fee is charged for review work when requested by insurance carriers or fiscal intermediaries.

The Specialty Panel method of peer review provides the private-practicing physician in Georgia a powerful voice in the way medical care is delivered in our state, one that will continue to increase in stature and strength as more physicians join the Foundation and become involved in Foundation review activities.

PSRO Report Adopted by the AMA

(Ed. Note: The following Report of the Board of Trustees and The Council on Medical Service, AMA, was amended and adopted by the House of Delegates at the December 1973 Clinical Convention in Anaheim, California. It is reprinted to clarify the position taken by the AMA at that time on Professional Standards Review Organizations.)

In the Report of the Board of Trustees and the Council on Medical Service on "Professional Standards Review Organizations," Report Z (C-72), the Association's concern over the PSRO program prior to its passage was noted. It should be recalled that the law was passed over the objections of the AMA and its spokesmen before Congress. However, the report noted that, since PL 92-603 has been adopted, the Council and the Board believed "that the American Medical Association should provide a dominant role of leadership in the implementation of the PSRO program to assure that the best interests of the public and the profession are preserved."

In line with this leadership role, specific responsibilities were assigned to the Advisory Committee created by House adoption of that Report, including development of rules and regulations, assisting state and county associations in developing PSROs, and furnishing material for the Council on Legislation in its development of future peer review legislation.

At the 1973 Annual Convention, in adopting substitute Resolution 49, the House recognized that repeal or modification of PSRO legislation "ultimately may be required to preserve the high quality of patient care." but instructed the Association to place "highest priority on developing and pursuing appropriate amendments to preserve the high quality of patient care." Board of Trustees Report A (C-73) at this session indicates that possible changes in the law are under study; information concerning this activity is incorporated with this report.

It is stressed that at all times the House of Delegates determines Association policy and that it is the role of the councils, committees, and the Board of Trustees to implement this policy.

For the information of the House of Delegates, the Board of Trustees and the Council on Medical Service feel obligated to make the following observations:

(1) Our very best information from Washington and bipartisan Congressional leadership is that there is no current political viability in an effort to repeal PSRO.

(2) Similar exploration suggests that there is Congressional receptivity to consideration of amendments to the law.

(3) "Non-participation" can be interpreted in several

ways. Non-participation by constituent and component medical societies refers to the unwillingness of such societies to cooperate in the development of PSROs. Non-participation by individual physicians implies unwillingness to provide professional reimbursable services for Medicare and Medicaid beneficiaries. In general, non-participation by organized medicine in the development of PSROs would be an abrogation by the profession of its responsibility to the public and the profession to assure that monitoring of the quality and cost of medical care is professionally oriented. Regardless of participation or non-participation by physicians or medical organizations, no physician can escape review of his Medicare and Medicaid services as long as the law remains in force.

(4) A significant proportion of the profession appears to agree that amendments to the law can improve it. The Board of Trustees and its Council on Legislation are currently preparing a series of amendments. (See Appendix A, attached.)

(5) Experience in developing the mandated AMA leadership role in PSRO implementation has identified many areas where such amendments may be necessary.

(6) Government resistance to Association recommendations in some areas indicates that, for certain facets of the program, amendment may be a more effective approach than attempts to influence regulations and directives.

(7) The PSRO law is widely interpreted as a cost control measure. However, there is reason to believe that it may generate costs in excess of savings.

(8) If PSRO legislation were to be repealed, other cost control measures now existing in law would be applied. Other legislative measures for cost containment would certainly be introduced.

In the light of the observations noted above, the options available to the Association are:

(A) To improve the law through development of regulations and administrative practices;

(B) To seek amendments to the law which would remove the undesirable features of the present statute;

(C) To promote repeal of the law;

(D) To suggest non-participation by all constituent and component societies. Such non-participation would specifically refer to the establishment of a PSRO by a unit of organized medicine.

Finally, it should be recognized that these options are not necessarily mutually exclusive.

The Board of Trustees and the Council on Medical Service are aware of the possibility that the House of Delegates could elect to support the idea of repeal of the law. However, the practical considerations indicate that this may be impossible to achieve, so that there should be a policy position which would prevail so long as the law remains in force.

The AMA affirms the following principles:

1. That the medical profession remains firmly committed to the principle of peer review, under professional direction, and

2. That medical society programs of proven effectiveness should not be dismantled by PSRO implementation, and

3. That the Association suggests that each hospital medical staff, working with the local medical society, continue to develop its own peer review, based upon principles of sound medical practice and documentable objective criteria, so as to certify that objective review of quality and utilization does take place; to make these review procedures sufficiently strong as to be unassailable by any outside party or parties; and that the local and state medical societies take all legal steps to resist the intrusion of any third party into the practice of medicine, and

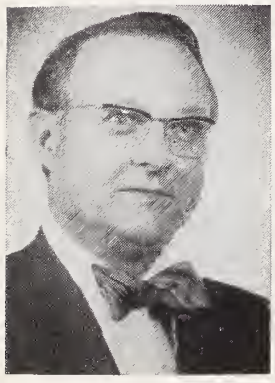
4. That this House of Delegates, as individual physicians and through the Board of Trustees and its Council on Legislation, work to inform the public and legislators as to the potential deleterious effects of this law on the quality, confidentiality and cost of medical care; and the hope that the Congress in their wisdom will respond by either repeal, modification, or interpretation of rules which will protect the public.

The considered opinion of this House of Delegates is that the best interests of the American people, our patients, would be served by the repeal of the present PSRO legislation. It is also believed that this is consistent with our long-standing policy and opposition to this legislation prior to passage.

The considered opinion of the Board of Trustees and the Council on Medical Service is to recommend to the House of Delegates that the AMA continue to exert its leadership and support constructive amendments to the PSRO law, coupled with continuation of the effort to develop appropriate rules and regulations.

president's letter

Taking Time for the Poor Patient



WHAT ARE WE THE PHYSICIANS of Georgia going to do about the problems of providing adequate health care for the poor patients of this state? The poor currently are Medicaid patients!

More and more physicians tell me, "I don't treat Medicaid patients." Why not? The most common answers are that there are adequate, more affluent patients and allowable Medicaid payments are too low. Numerous Medicaid patients seek medical attention for imagined illnesses or vague, non-specific symptoms, hence utilizing valuable time and facilities that would be beneficial to truly ill patients. Some physicians simply refuse to treat someone whose fee will be paid by the government.

These are valid arguments and I will be the first to defend a physician's right to treat whom he pleases, and his right to refuse to treat whom he pleases.

We must, however, in some manner, provide care for these people. Failure to do so will surely lead to groups or organizations with state and/or federal funding providing health care for this segment of our medical practice, and I do feel we cannot afford to lose it for several reasons. The poor population is a large one and is very vocal. They will remain our friends so long as we take the time to care for their ills and listen to the many problems that are theirs, problems that are usually secondary to the bottom-of-the-ladder status of the poor.

Generally speaking, the majority of Medicaid patients in Georgia have access to private practitioners, but in some of our urban areas significant numbers of these people must seek care in huge, impersonal hospital emergency rooms where continuity of care is impossible or impractical.

I do not know the answer, but I do know that it is steadily becoming a greater problem and will surely eventually develop into a very real monster, a monster capable of consuming the private practice of medicine. Perhaps we will have to name him HMO!



Charles Emory Bohler, M.D.
President, Medical Association of Georgia

Mid Systolic Click—Late Systolic Murmur Syndrome (Barlow's Syndrome): A Review

DAVID L. STEINBERG, M.D., *Atlanta**

THE MID-SYSTOLIC CLICK—late systolic murmur syndrome is a commonly occurring cardiac abnormality. The syndrome is characterized by prolapse of one or both mitral valve leaflets into the left atrium in mid to late systole. The click is felt to be due to abrupt tensing of chordae tendinae as prolapse occurs, whereas the late systolic murmur is a result of the consequent mitral regurgitation.

Although at first felt to be a distinct clinical entity by Barlow, the syndrome has now been described in a variety of cardiac disorders such as atrial septal defect, cardiomyopathy and coronary atherosclerotic heart disease. In addition it occurs in disorders of connective tissue such as Marfan's syndrome. Certainly it would appear that an "idiopathic" variety occurs as well which may be familial.

The purpose of this brief review is to describe the clinical features, the laboratory diagnosis and the treatment of the various aspects of this syndrome.

Clinical Feature

Clinically, the syndrome is characterized by chest pain, cardiac arrhythmias and characteristic abnormalities on cardiac examination. The chest discomfort at times is consistent with angina pectoris, but more often is vague and ill-described. Symptoms of hyperventilation are common. The cardiac arrhythmias may be supraventricular or ventricular, benign or malignant, symptomatic or asymptomatic. Sudden death presumed to be secondary to cardiac arrhythmia has been reported. When examining patients with connective tissue disorders, documented coronary atherosclerotic heart disease or atrial septal defect, the click—late systolic murmur syndrome should be specifically sought by the physician.

On physical examination the pathognomonic finding is the presence of a mid-systolic click or the combination of a mid-systolic click and a late systolic murmur. The degree of mitral regurgitation is usually minimal so there is no displacement of the cardiac apical impulse. However, there are exceptions to this rule in severe cases. In addition one may rarely feel an apical mid-to-late systolic retraction which coincides with the click as traction is placed on the left ventricular apex in response to prolapse of the mitral valve leaflet(s). This motion may be better elucidated by apexcardiography.

On auscultation of the heart, the abnormalities are confined to mid and late systole. It should be emphasized that ausculatory findings may vary in a given individual on repeated examinations, the discrepancies presumably explainable by varying degrees of leaflet prolapse. In addition various "maneuvers" are helpful in attempting to substantiate the diagnosis. The non-ejection click occurs at least 0.14

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seconds after the first heart sound in the supine position and may or may not be followed by a late systolic murmur. The response of the click and/or murmur to changes in position (lying, sitting, standing), and when necessary, to infusion of phenylephrine or inhalation of amyl nitrite should be noted.

Generally, any maneuver which decreases the size of the left ventricular cavity during systole increases the degree of redundancy of the already-too-long chordae and hence also the degree of mitral regurgitation. Sitting or especially standing, therefore, would be expected, by decreasing venous return to the heart, to result in earlier mitral leaflet prolapse and earlier mitral regurgitation. Thus the click would move toward early systole and the murmur, if present, would get longer. Phenylephrine would be expected, by increasing the pressure gradient between the left ventricle and left atrium in systole, to increase the intensity of the systolic murmur if present. However the murmur is not lengthened because the increased left ventricular systolic volume decreases the degree of chordal laxity and thus decreases the degree of mitral regurgitation.

Conversely, amyl nitrite decreases the systolic pressure gradient between the left ventricle and left atrium with a consequent diminution in the intensity of the systolic murmur. But, because of a smaller left ventricular cavity size prolapse occurs earlier and the click occurs earlier and the murmur gets longer.

Electrocardiographic abnormalities are common in the syndrome, although these are not diagnostic. The changes are for the most part confined to repolarization and consist of prolongation of the Q-T interval and abnormal prominence of the "U" waves. In addition non-specific "T" wave changes have been described, primarily in the inferior leads II, III, and AVF, consisting of flattening or inversions. Depolarization abnormalities have more recently been described, once again involving the inferior leads, mimicking a "dead zone" with "Q" waves apparent in leads II, III, and AVF. Treadmill testing has revealed positive "ischemic" ST segment changes in some individuals with this syndrome and hence it may be viewed as one cause of a "false positive" exercise test.

Echocardiogram

The echocardiogram has proven to be a useful diagnostic tool in the recognition of Barlow's syndrome. Posterior displacement of one or both leaflets of the mitral valve in mid to late systole rather than the normal anterior motion of these structures is diagnostic of mitral prolapse.

Cardiac catheterization reveals diagnostic abnormalities in this syndrome. Angiographic evidence of late systolic mitral leaflet prolapse is usually apparent. In addition, a curious late systolic deformity of the inferior wall of the left ventricle occurs as the tensed chordae tendinae exert traction on this portion of the left ventricular wall during leaflet prolapse. It should be stressed, however, that the syndrome can usually be diagnosed clinically and by echocardiogram and that cardiac catheterization is not necessary for its diagnosis.

The clinical significance of this syndrome is related to its confusion with coronary atherosclerotic heart disease, the production of cardiac arrhythmias, its potential predisposition to infective endocarditis and, in some cases, its progression to severe, life-threatening mitral regurgitation. Difficulty sometimes arises in differentiating the chest pain syndrome of "idiopathic" mitral leaflet prolapse from that of angina pectoris secondary to coronary atherosclerotic heart disease. This situation arises especially in those patients who are a high risk to develop coronary atherosclerosis. The difficulty is complicated by the not-so-infrequent coexistence of the prolapsing valve and coronary atherosclerotic heart disease. Here, cardiac catheterization may be of value in clarifying the dilemma.

Cardiac arrhythmias may be either ventricular or supraventricular and may run

the entire clinical spectrum of toxicity. Sudden death has been reported and is felt to be the result of ventricular arrhythmias. Stress testing may bring to expression a latent but potentially serious arrhythmia, and may be extremely helpful in the patient with symptoms suggestive of paroxysmal tachyarrhythmia. Inderal has proved beneficial in controlling the arrhythmias associated with the syndrome.

Bacterial endocarditis, though rare, has been reported and hence endocarditis prophylaxis is probably indicated in all patients with either an isolated click or a combined click and murmur.

Although the degree of mitral regurgitation is usually not clinically significant, a small group of patients develop severe mitral incompetence necessitating prosthetic valve replacement. This problem seems to occur in a group of patients with myxomatous degeneration of the mitral valve and could of course also occur as a result of infective endocarditis.

In Summary

In summary, the mid-systolic click—late systolic murmur syndrome may be found as a relatively pure anomaly or in association with several types of acquired heart diseases or connective tissue disorders. The diagnosis can usually be made clinically and may be confirmed in the majority of cases by non-invasive techniques, specifically echocardiography. The major problems posed to the clinician are:

1. Differentiation of chest pain from true angina pectoris
2. The diagnosis and treatment of cardiac arrhythmias
3. The instruction of the patient in bacterial endocarditis prophylaxis
4. The recognition of progressively severe mitral regurgitation in a small number of patients.

Inderal has proven an effective anti-arrhythmic agent in this syndrome, and rarely mitral valve replacement may be required. ■

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Gynecology Oncology Course Offered in April

The Department of Gynecology and Obstetrics of the Emory University School of Medicine announces a postgraduate course in Neoplasia of the Female Genital Tract April 8-10, 1974.

The course will include: 1) A two-day seminar on carcinoma of the cervix, endometrium, vulva and ovary; 2) Workshops on carcinoma of the ovary and endometrium; and 3) A one-day course in colposcopy, basic and advanced, with lectures, instruction and patient demonstration.

The guest faculty will include John Frost, M.D., of Baltimore, Md., James W. Reagan, M.D., Cleveland, Ohio, Ralph Richart, M.D., New York City, Adolph Stafl, M.D., Ph.D., Milwaukee, Wis. and Duane E. Townsend, M.D., Los Angeles, Calif.

For catalogue and applications write to the Division of Continuing Education, Dept. of Gynecology and Obstetrics, Emory University School of Medicine, 69 Butler St., Atlanta, Ga. 30303. Telephone (404) 659-0289.

Phase IV Economic Stabilization Program Pricing Regulations as Applied to Physicians

JEFFREY L. RANEY, *Atlanta**

On January 23, 1974, the Cost of Living Council (CLC) published new regulations governing the allowable price increases charged by providers of institutional and non-institutional health care. The purpose of this article is to summarize the general applicability of these new regulations to the prices which a medical practitioner may charge for his services. In making this summary it was necessary for the author to interpret certain provisions of the new regulations as published, with the assistance of officials of the CLC contacted in Washington, D.C. Since this summary is general in scope and is subject to interpretation, the guidelines set forth herein should not be relied upon for a specific situation without first referring to the regulations or interpretive releases or modifications of these regulations to determine if different rules may be applicable.

Effective January 1, 1974, the allowable price increases and overall profit margins afforded medical practitioners are governed by Subpart R of the Phase IV regulations as set forth in 6 CFR Part 150 (the "Guidelines"). Within Subpart R, Sections 150.730 through 150.743 govern allowable price increases for medical practitioners. As defined in the Guidelines the term "medical practitioner" means a physician, surgeon, osteopathic physician, dentist, dental surgeon or podiatrist, and, in addition, applies to an individual practicing alone, or a group of individuals practicing together in the form of a professional partnership, association or corporation.

Price Increase Limitations

Subject to the profit margin limitations set forth below, the allowable prices to be charged by a medical practitioner during any given calendar year are subject to an overall percentage increase limitation as well as an individual percentage increase limitation. These rules are as follows:

Overall Price Increase Limitations

The overall increase in customary prices for all services rendered by a medical practitioner in any one calendar year may not exceed the overall customary prices legally in effect on the last day of the immediately preceding calendar year by an amount in excess of the Overall Percentage Increase as computed on an aggregate weighted basis.

The term "customary prices" as used in the Guidelines is defined as the price

*Prepared at the request of The Medical Association of Georgia. Mr. Raney is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, Atlanta, Ga. 30303.

which was or would be charged in a substantial number of transactions to a class of purchasers for that particular service.

While the Guidelines do not define what constitutes a "substantial number of transactions," under Phase II rules that term with respect to determining the "base price," was the highest price, at or above which, at least 10 per cent of those units were priced by the seller in transactions with that class of purchasers during the base period. Applying this 10 per cent test to medical practitioners would be consistent with the CLC's intent that the "customary price" equal that price which is or was the customary charge for a service rather than the exceptional or extraordinary charge.

As an example, if the 10 per cent test were to be applied in determining the customary price for a given service performed by a physician and that physician performed a particular service for 20 patients during the relevant period with 15 patients being charged $18; three patients being charged $19; one patient being charged $20; and one patient being charged $21; the customary price for that period would be $20 since 10 per cent of the patients were charged $20 or more.

The term "Overall Percentage Increase" as used herein is an amount equal to 104 per cent plus any unused aggregate price increases permitted under prior phases of the Economic Stabilization Program or the Guidelines. For example, if a medical practitioner has not increased his medical fees during the two-year period ending December 31, 1973, the permitted Overall Percentage Increase for the 1974 calendar year would be 109 per cent (104 per cent + 2.5 per cent + 2.5 per cent).

As indicated above, the permitted Overall Percentage Increase in any given calendar year is determined on a weighted basis. The weighted-basis formula, as set forth in Section 150.734 of the Guidelines, in essence requires the medical practitioner to calculate the price increases for all services in order to determine the Overall Percentage Increase and in doing that the price for each service shall be adjusted by the ratio that the volume of business for that service in the preceding calendar year bears to the total volume of business for all services provided by that medical practitioner during the preceding calendar year. The Guidelines provide that this weighted basis computation can be avoided if the medical practitioner elects not to increase the price for any service in excess of the Overall Percentage Increase permitted for that year.

As an example, if a medical practitioner had available to him an Overall Percentage Increase in calendar year 1974 equal to 105 per cent, he could, subject to the revenue margin limitations hereinafter set forth, uniformly raise his customary prices 5 per cent for all services without making the weighted basic calculations. The Guidelines further provide that if a medical practitioner limits all individual price increases to less than or equal to the Overall Percentage Increase, the resulting price for any given service can be rounded off to the nearest quarter dollar. However, CLC officials have interpreted this provision as being limited to the situation where the resulting rounding to the nearest quarter dollar will not exceed the Overall Percentage Increase. Accordingly, if a medical practitioner applied a permitted 105 per cent Overall Percentage Increase to an individual service which had a customary price of $9 at the end of the preceding calendar year, the maximum price he could charge is $9.45 since a rounded figure of $9.50 would exceed the maximum of 105 per cent which must be used if the aggregate weighted basis computation is to be avoided.

Individual Pricing Limitations

The Guidelines provide that the maximum price permitted to be charged for any one service may not exceed 110 per cent of the customary price lawfully in effect for that service on the last day of the immediately preceding calendar year, provided, however, that the resulting price increase need not be less than $1. As an example, if a medical practitioner decides to increase prices for individual services in

excess of the Overall Percentage Increase, he could increase prices for any given service 10 per cent over the customary price in effect on the last day of the preceding calendar year or $1, whichever is greater. As applied to a customary price of $9 in effect as of the end of the preceding calendar year, this means that he could raise that charge to $10 but with the proviso that the resulting overall percentage increase for all services for the current calendar year does not exceed the Overall Percentage Increase.

Profit Margin Limitations

In addition to the price increase limitations summarized above, the Guidelines further provide that a medical practitioner can only implement price increases above the levels lawfully in effect on the last day of the immediately preceding *fiscal* year if his current fiscal year revenue margin does not exceed his base period revenue margins.

The term "revenue margin" means profit margin and is defined in the Guidelines as the ratio that net revenues (aggregate revenues less total operating expenses directly related to the provision of health care) for the fiscal year in question bear to the aggregate annual revenues for that fiscal year computed in accordance with generally accepted accounting principles consistently applied. The Guidelines further provide that medical practitioners practicing in a partnership must exclude from operating expenses any salaries paid to employees who are medical practitioners deriving more than 50 per cent of their professional income as employees of that partnership. In addition, if a medical practitioner is incorporated during or subsequent to the base period, the medical practitioner shall exclude from operating expenses all amounts of salaries and deferred compensation in excess of that permitted under a Keogh Plan for any individual medical practitioner who is an employee-owner for the purposes of applying the revenue margin limitation test.

The "base period revenue margin" is the revenue margin of any two of the practitioner's fiscal years ending after August 15, 1968 and prior to the fiscal year for which compliance is measured. The "current fiscal year revenue margin" as that term is used herein is determined as follows:

1. If the price increase is to be made during the first fiscal quarter of the current fiscal year the current fiscal year revenue margin will be the projected revenue margin for the current fiscal year based upon projections of cost increases to be incurred by the medical practitioner during that period of time.
2. If the price increase is to be implemented after the first fiscal quarter, the current fiscal year revenue margin will be the projected revenue margin for the remainder of the current and next succeeding fiscal year, based upon projections of cost increases to be incurred by the medical practitioner during that period of time.

As an example, if a medical practitioner's fiscal year coincides with his calendar year he must, in implementing a price increase within the first three months of 1974, project what his operating costs and expenses will be during the full calendar year, and, based upon those projections together with the revenues to be derived from the increased prices, determine a current fiscal year revenue margin. That current fiscal year revenue margin cannot exceed his base period revenue margin.

Posting Requirements

Each medical practitioner, whether or not he has increased prices, is required to maintain a current schedule showing his customary prices in effect on December 28, 1973 for each class of purchaser for his principal services (i.e. those constituting 90 per cent of his aggregate annual revenues) and note on that schedule the date and amount of each subsequent change in the price of these services. If price

increases are implemented on an aggregate weighted basis, the weights of each service or group of related services whose prices are increased shall also be shown on the schedule. The schedule must be made available for public inspection and a copy furnished to any third party payor or CLC representative upon request. Notice of the availability and location of this schedule must be conspiciously posted in the medical practitioner's facilities. No price increase may be made before the notice is posted and the schedule made available for public inspection.

Exceptions

Unless a medical practitioner has requested and received an exception from the CLC, he may not implement a price increase that would exceed the percentage price increase or revenue margin limitations summarized above. The Guidelines have streamlined the exception request procedures for medical practitioners by providing that any such request shall be considered to have been provisionally approved if the petitioner has not received a suspension notice from the CLC within 60 days after the date of filing of the request with the CLC. Price increases which are implemented as a result of the expiration of the 60-day period may be modified, deferred, suspended or disapproved if the CLC thereafter finds that the increase is inconsistent with the Guidelines or unreasonably inconsistent with the goals of the Economic Stabilization Program. If the CLC does act, the medical practitioner will not be required to refund any monies received or to reduce reimbursements otherwise allowed; nor shall he be subject to any criminal fine or civil penalty on account of that increase if the exception request had been submitted in good faith.

In considering requests by medical practitioners for an exception to a revenue margin limitation, the Guidelines set forth the various factors which the CLC will consider in determining if an exception should be granted.

Remedies for Non-Compliance

In the event that a medical practitioner's revenue margin or price increase exceeds that permitted under the Guidelines, and no exception has been granted, or permitted to go into effect, the CLC may order a reduction or refund of excess amounts or such other action as deemed appropriate. In addition the civil or criminal sanctions provided under the Guidelines may be imposed. ■

Breast Cancer Screening Projects Test Non-Symptomatic Women

Twenty-seven Breast Cancer Screening Projects have been established geographically over the United States by the American Cancer Society and the National Cancer Institute. The Atlanta Project, shared by the Georgia Baptist Hospital and Emory University, has been in operation since last summer. These Projects accept *non*-symptomatic women to screen their breasts by clinical examination, thermography, and xerography. The purpose is to find a better way of screening asymptomatic women, to better define the high-risk group who should be screened, and to demonstrate that breast cancer can be detected by these methods early in a more curable stage.

As of December 1, 1973, 1,302 women have been screened, and we have found eight malignant tumors. The important fact is that seven of these malignancies could not be felt clinically, but were found by biopsying the area shown on the xerograms. None of these had metastatic disease.

To be screened, women should call the county unit of the American Cancer Society to make appointments. We will accept about 10,000 women for screening in the next two years. These women will be followed until the end of a five-year period by annual screening, and then followed up to 10 years by contact.

I've told this before . . . .

(Ed. note: Time can blur the difference between truth and exaggeration in stories about favorite hunting dogs, author J. G. McDaniel of Atlanta has learned. But in "Adolph's" case—well, he was different. Contributions to this page should be sent to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Adolph—A Bird Dog

RECENTLY I WENT ON a quail hunt with Dr. George Holloway and Mr. Emory (Muddy) Waters, a retired airline pilot. We went up to Charlotte, N.C., to a hunting preserve owned by a man by the name of Mack Ballard. He releases birds on his place from time to time that are raised in a large enclosure.

The hunt was quite rewarding and most pleasurable, primarily because of the outstanding performance of the dogs. Mr. Ballard has Drathaar bird dogs. They are German dogs—ugly, unless they are on a point, hunting or retrieving. They look kinda like a big wirehaired terrier mixed up with something, but they are gentle and quite intelligent.

The first morning was drizzling rain and foggy—not enough to wet you, but just enough to be worrisome. Mack assigned us a dog by the name of Alex, since Muddy had hunted with him before, and told us where to go. I was a little surprised by being given only one dog and no guide, but since I was a neophyte, I kept my mouth shut.

We hadn't gone more than a 100 yards before Alex pointed. Two birds got up, George missed his, which he usually does on the first one, but seldom thereafter. Muddy downed his. They commenced walking on pretty much unconcerned. I said, "Aren't you going to get your bird" and about that time Alex appeared with the bird.

And so it went all the morning. We never worried about finding a dead bird; if a bird's legs dropped when shot at, he usually noted it, and although it might fly some little distance, Alex would find it and retrieve it.

At the close of each day, the hunters gathered around a big open fire in a barn-like room and tried to explain why they had shot so many shells and killed so few birds in proportion. All through these discussions at eventide I kept hearing the name of Adolph, and when his name was brought up, there was a silence among the old hunters who knew him. They bowed their heads as though the cross was passing in the holy church, and slowly moved their heads from side to side. "That was a dog" they said over and over again.

"Will somebody," I finally said, "please tell me who this Adolph was. I do not seem to have heard of him, although I am an avid reader of most sporting magazines." This was like asking a hypochondriac how he felt. They promptly told me.

Adolph was a pure-bred Drathaar from Germany, given to Mr. Mack as a puppy in the early 60's. He was registered by the name of Adolph and even though he was German, he soon learned to understand North Carolina English.

Primary, of course, they extolled his virtues as a hunter and a retriever . . . when he pointed, there was always a bird there and if you thought you downed a bird and he did not bring him back, you just thought you did. And fellow hunters had a few choice remarks to make after such events.

Mack told about the time that he retrieved three birds in his mouth at one time, and when I asked, with tongue in cheek, if he did not point a bird on his way in,

he looked hurt and said that that was the reason he seldom talked about Adolph's greatness, because people would think he was either lying or crazy.

One hunter told a story about the time it commenced raining and he had left his rain jacket on a bench inside the lodge. Mack told Adolph to go there, get the jacket and bring it. He did. Another told about the time that Adolph and Tiger, his son, each had a bird pointed about 100 feet apart. Mack called to Adolph to leave his point and come over there. He did. Two birds were shot and retrieved. Adolph was told to go back to his bird. He did, promptly pointing him.

And then they told the story about Mack telling Adolph to clean up the place—he immediately commenced picking up from the floor all cigar and cigarette butts, Coca-Cola caps, tissues, etc. and putting them in a trash can.

George Holloway swears that he purposely dropped his keys behind his car one night, to test Adolph. He went in and told Mack. Mack called to Adolph and said, "Dr. Holloway lost his keys behind his car; go find them." Within a few minutes he was back, with the keys in his mouth.

Mr. Nelson Bryant wrote a story in the *New York Times* about secreting a small box several hundred yards away and Adolph finding and fetching it on request.

And so it went; I soon decided that either Adolph was a super dog, or I was in the midst of the most accomplished prevaricators in the United States.

During much of this time I was watching five hearty suckling pups, nursing their contented mother; they seemed happy and quite healthy. When I made a simple remark to Mack Ballard about how they had all the marks of making fine dogs, Mack sucked in his belly until I thought his britches would fall off, threw out his chest and said, "They will; they are the great, great grandchildren of Adolph."

It was then I decided that these people could be telling the truth.

Atlanta Physicians Recognized for Many Years of Practice

The Medical Association of Atlanta honored several members who have been in practice 50 years, 25 years or who are eligible for life membership at the Association's annual banquet in February.

Newly installed president Edwin C. Evans, M.D. awarded the certificates at the Academy of Medicine.

The 1973 Aven Cup Award for outstanding community service was presented to Asa G. Yancey, M.D. at the banquet. Dr. Yancey is a surgeon and medical director of Grady Memorial Hospital and Hughes Spalding Pavilion and is a member of the Atlanta Board of Education.

The Aven Cup Award was established in 1954 by Dr. and Mrs. Carl Aven as a means of recognizing and encouraging greater participation by physicians in activities of community benefit.

MAA members receiving 50 Year Certificates include: F. Lee Bivings, Zach W. Jackson, Clifton G. Kemper and R. Hugh Wood.

Twenty-five Year Certificates were presented to: Louis Berger, J. Gordon Brackett, Robert H. Brown, David B. Dennison, Ernest B. Dunlap, J. Willis Hurst, J. Dudley King, William M. Lester, Stewart M. Long, Wood W. Lovell, Harry C. Lyon, W. Spence McClelland, Lila Bonner Miller, William W. Moore, Jr., Michael V. Murphy, Jr., Morgan B. Raiford, George S. Roach, Jr., Joel P. Smith, Sr., William R. Thompson, and Seymour P. Weinberg.

Nine were given life memberships: B. Russell Burke, Elizabeth Gambrell, A. H. Germain, J. G. McDaniel, W. Mercer Moncrief, Samuel W. Perry, Charles E. Ruskin, Carter Smith, Sr. and John R. Walker.

EMORY "CONTRACEPTIVE TECHNOLOGY" MANUAL GOES INTO SIXTH EDITION

The sixth edition of "Contraceptive Technology" has been published by the Emory University Family Planning Program of the Department of Gynecology and Obstetrics.

For the first time the manual will be translated into Spanish. Ten thousand copies have gone to the national Planned Parenthood headquarters in New York City, and another 10,000 will be sold to medical schools and health organizations throughout the country.

The manual contains information about the latest contraceptive techniques, discusses the menstrual cycle, pregnancy testing, techniques of the future, principles of family planning, health benefits of family planning, failure rates of the various contraceptive methods and case histories using the new problem-oriented record system.

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NEW MEMBERS

Aboul-Khair, Sidky A. Richmond—Active—I	Medical College of Georgia Augusta, Ga. 30904
Allan, Christopher J. Fulton—Active—PA	1000 Johnson Ferry Road Atlanta, Ga. 30342
Arrue, Luis R. Fulton—Active—PD	217 Arrowhead Blvd. Jonesboro, Ga. 30236
Braddock, Henry A. Fulton—Active—FP	1862 Princeton Dr. College Park, Ga. 30337
Burns, James B. Fulton—Active—R	3312 Piedmont Road, N. E. Atlanta, Ga. 30305
Davis, Thomas A. Fulton—Active—P	1999 Cliff Valley Way, N. E. Atlanta, Ga. 30329
DeNaples, Mark A. Richmond—Active—NS	1136 Druid Park Ave. Augusta, Ga. 30904
Easley, Conrad H. Whitfield—Murray—SU	1401 Burleyson Dr. Dalton, Ga. 30720
Fishbein, Sumner L. Richmond—Active—OPH	171 Harrison Ave. Boston, Mass. 02111
Gilner, Donald M. Fulton—Active—AL	960 Johnson Ferry Road, Ste. 530 Atlanta, Ga. 30342
Goldman, John A. Fulton—Active—I	1365 Clifton Road, N. E. Atlanta, Ga. 30322
Herrin, Eugene VanLandingham Crawford W. Long—Active—OBG	740 Prince Ave. Athens, Ga. 30601
Hudson, Harold J. Mitchell—Active—FP	25 Perry Ave. Camilla, Ga. 31730
Jackson, James G., III Richmond—Active—OR	1140 Druid Park Ave. Augusta, Ga. 30904
King, James T., Jr. Fulton—Active—SU	340 Boulevard, N. E. Atlanta, Ga. 30312
Konaci, Yuksel Fulton—Associate—PATH	Emory University, Path. Dept. Atlanta, Ga. 30322
Levin, Richard L. Fulton—Active—D	6500 Vernon Woods Dr. Atlanta, Ga. 30328
Lewis, Ronel L. Muscogee—Service—P	P. O. Box 596 Ft. Benning, Ga. 31905
Liebelt, Robert A. Richmond—Active—Ac M	Medical College of Georgia Augusta, Ga. 30904
Lievano, Alvaro Fulton—Active—SU	1203 Cleveland Ave. East Point, Ga. 30344
Marcucci, Miguel A. Cobb—Active—SU	2404 Austell Road Austell, Ga. 30001
McFarland, Dee Edward Richmond—Active—PATH	1350 Winn Way Augusta, Ga. 30904
O'Brien, David P., III Fulton—Active—U	1365 Clifton Road, N. E. Atlanta, Ga. 30322
Pessolano, Louis C. Richmond—Active	P. O. Box 5826 Augusta, Ga. 30904
Regalado, Jacinto E. Baldwin—Active	299 Youngblood Circle Milledgeville, Ga. 31061
Robinson, Jerry C. C-D-H—Active—R	Tanner Memorial Hospital Carrollton, Ga. 30117
Salam, Atef A. Fulton—Active—SU	Room 302, 69 Butler St. Atlanta, Ga. 30303
Sapp, Gerald L. Tift—Active—OR	Corner 4th & Central Tifton, Ga. 31794
Vasconez, Luis O. Fulton—Active PL	1365 Clifton Road, N. E. Atlanta, Ga. 30322
Wells, Theron W., Jr. Muscogee—DE4—OPH	Martin Army Hospital Ft. Benning, Ga. 31905
White, John W. Muscogee—Service—SU	Martin Army Hospital Ft. Benning, Ga. 31905
Zubowicz, George Muscogee—Active—P	2000 Sixteenth Ave. Columbus, Ga. 31901

SOCIETIES

The February 18 meeting of the **DeKalb County Medical Society** concerned the topic, "The Current Status of Renal Transplantation in Atlanta," discussed by Ernest Lewis, M.D. of Emory University Clinic.

AMA president Russell Roth covered the topic "Pills, Patients & Politics" at the February 12 dinner meeting of the **Medical Association of Atlanta.**

The annual meeting of the **Meriwether-Harris County Medical Society** was held January 7 at the Georgia Warm Springs Foundation and featured Joseph M. Almand, Jr., M.D., LaGrange as guest speaker.

New officers were elected at the meeting: Emmett Collins, Manchester, president and MAG alternate delegate; A. Connor Higgins, president-elect; Bill Chambliss, Hamilton, secretary-treasurer; Calvin Jackson, Manchester, MAG delegate; J. W. Smith, Manchester, Blue Cross-Blue Shield representative.

PERSONALS

First District

John H. West, Savannah, diplomate of the American Board of Internal Medicine, was certified recently by the board as a diplomate in the subspecialty of oncology. Dr. West serves as chairman of the Oncology Department at Memorial Medical Center.

Fourth District

E. R. Leverett, formerly practicing in Hogansville, has joined the staff of Clark-Holder Clinic in LaGrange. Dr. Leverett was graduated from the Medical College of Georgia in 1956 and interned at Athens General Hospital.

Fifth District

Lamont Henry was featured in an article appearing in the January 18 *Atlanta Constitution* on his retirement as team physician for Georgia Institute of Technology, a position he occupied for 21 of the last 37 seasons.

William H. Jarrett, II of Atlanta is the author of "One Hundred Consecutive Cases of Retinal Detachment," which appeared in the February issue of the *Southern Medical Journal*. **Samuel B. Chyatte** and **Joseph H. Patterson** are two of five authors of the article "Human Growth Hormone in Myopathy: Myotonic Dystrophy, Duchenne Muscular Dystrophy and Limb-Girdle Muscular Dystrophy," which also was printed in that issue.

Seventh District

Donald Rooney, Marietta, has been nominated for a three-year term on the Board of Chancellors of the American College of Radiology. Nominations will be subject to approval of the College membership at its 51st Annual Meeting April 1-5, 1974 in New Orleans. La.

Tenth District

Elwyn A. Saunders of Augusta is one of three authors of "Posterolateral Spine Fusion With and Without Nerve Root Decompression: A Primary Procedure for Low Back Pain," which appeared in the February *Southern Medical Journal*.

Four Medical College of Georgia administrators have received new assignments: Lois T. Ellison will succeed Russell R. Moores as associate dean for curriculum: Dr. Moores is to be appointed associate dean for special programs; Winford H. Pool will succeed Mark Brown as chairman of the Department of Radiology; Dr. Brown has requested changes to allow him more time to pursue clinical and research aspects of radiology.



The February 10 Open House of the new Georgia Academy of Family Physicians headquarters drew (seated, L-R) William Lotterhos, Augusta, past president of the AAFP; and James G. Price, Brush, Colo., current AAFP president. Standing are (L-R) Edwin Flournoy, Albany, GAFP president; R. D. Walter, Calhoun; James G. Jones, Jacksonville, Fla., regional advisor for AAFP; James Dismuke, Adel; and Ollie O. McGahee, Jesup. The headquarters is located in Suite 205, 11 Corporate Square, Atlanta, Ga. 30329.

DEATHS

H. Walker Jernigan

H. Walker Jernigan, who served as an orthopedic surgeon in Atlanta 40 years, died January 23.

A native of White Plains, Dr. Jernigan was graduated from Emory University School of Medicine and was an intern in Atlanta and New York. He served in the U. S. Navy Medical Corps during World War II. He had served as president of the medical staffs of Georgia Baptist and Crawford Long Hospitals and was past president of the Atlanta Orthopedic Society.

Survivors include his widow; daughter, Mrs. William D. Heisel of Atlanta; and brother, G. Jarrell Jernigan of Imperial Beach, Calif.

The Month in Washington

The American Medical Association has branded as "wrong medically, wrong morally, and wrong legally" the Health, Education, and Welfare Department's proposed regulation requiring pre-hospital-admission certification for Medicare and Medicaid patients.

In what appeared as an ending to a "deliberate effort on the part of the AMA over the past four or five years to cooperate with HEW," the Association announced that if the pre-admission certification regulation and the Professional Standards Review Organizations area designations were placed into effect, HEW Secretary Caspar Weinberger would be taken into court.

AMA in Court?

AMA President Russell B. Roth, M.D. and Board Chairman James H. Sammons, M.D. at a press conference in Chicago made the following statement:

"We are here today to serve notice on Secretary Weinberger that if he proceeds with two proposed actions, we are going to take him to court.

"Earlier this month, the Secretary of the Department of Health, Education, and Welfare issued a set of proposed regulations that would require pre-admission certification for Medicare and Medicaid. If adopted as proposed they would require that every Medicare and Medicaid patient be cleared by a Utilization Review Committee before admission to a hospital. The only exception would be emergency cases.

"These regulations are a direct threat to the medical care of the 35 million or so patients who are served by Medicare and Medicaid. For most of them, the withholding of Medicare or Medicaid hospital benefits will mean that the individual will be denied hospitalization because they have no other means to pay for their care.

"Furthermore, such decisions would not be made on the basis of an examination of the patient by physicians. Rather, they would be paper decisions. The verdict would be rendered on the basis of what the patient's doctor put down on the record. It is likely that, as a practical matter in many instances, the decision would not be made by a committee of physicians or even a single physician but by an admitting nurse or other hospital administrative personnel.

Violation of the Law

"Any such denial of medical care represents a clear violation of both the spirit and the letter of the Medicare-Medicaid law. Congress clearly established the programs to provide medical care for the elderly and the poor. What the Congress has given, the Secretary now seeks to take away. The Secretary has no authority

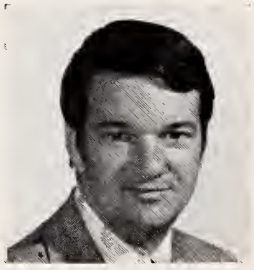
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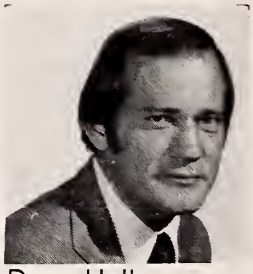




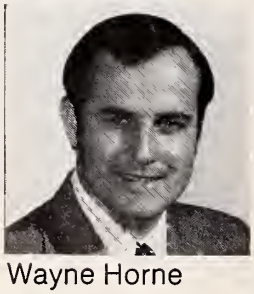
Jim Andrews



Steve Eades



Doug Hall



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under the guise of regulations to amend the law and reduce benefits. He has no moral or legal right or authority to do so. Indeed, his action is as illegal as it is reprehensible. The Medicare-Medicaid law provides for pre-admission certification by the patient's physician and for post-admission review by hospital utilization review committees. The Congress did not intend that a committee substitute a paper decision for the judgment of a patient's physician. The Secretary's proposal is a direct and clear violation of Section 1801 of the Medicare-Medicaid law.

"We intend to fight Mr. Weinberger on this. His proposed regulations are wrong medically, wrong morally, and wrong legally. We are here to serve notice on the Secretary that if he persists in putting the regulations into effect, the AMA will seek an injunction on that very same day to stop him.

"We would welcome support from all interested parties, such as senior citizen organizations and consumer groups. We would hope they would join in our action. But with them or without them, we will be in court on the day those regulations are promulgated.

"While we are in a suing mood, let me mention that we are also going to take on Mr. Weinberger in another area.

"This involves his gerrymandering of the PSRO district. Without getting too involved, let me say for those of you who don't know, PSRO stands for Professional Standards Review Organizations. These are supposed to be groups of doctors set up to review the quality and medical necessity of care given under Medicare and Medicaid.

"The AMA originally opposed PSRO. But once it became law, we decided that if such review was going to be done it would be better for all concerned if it were done by physicians.

"We decided to cooperate with HEW in the implementation of the law. I can tell you, we've had very little cooperation in return.

"Peer review—the concept on which PSRO is based—was invented by the medical profession and was in existence long before the government ever heard of the idea. There are many excellent and functioning peer review programs now in effect in this country, and we asked the Secretary to set up the PSRO designated areas (regional units) so as not to disturb them.

"This plea apparently fell on deaf ears. I won't hazard a guess as to the reason behind the Secretary's area designations. I don't think there were any. I think the decision was simply capricious and arbitrary.

"Our Board of Trustees has voted to join with any of our state organizations who want to go to court to upset the area designation in their state. Our preliminary indications are that seven or eight may do so.

"Let me say in closing that over the past four or five years we have made a deliberate effort to cooperate with HEW in implementing government programs for the benefit of the people. I think for a while there was good communication and good cooperation.

"That day apparently has passed. Of late we've had

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nothing but rebuff after rebuff. We've now been left with no recourse but to fight in our own best interests and, we believe, in the best interest of our patients."

Wage and Price Controls

Physician fees in 1974 have been ordered held to a four per cent increase by the Cost of Living Council.

Despite strong arguments from physician groups including the AMA for an exemption from all wage and price controls for the medical profession, the Council refused to step back from its November proposal to impose the 4 per cent ceiling.

As in November regulations, physicians under Phase IV will be permitted an annual aggregate fee increase of 4 per cent. A 10 per cent maximum fee increase is allowed for specific charge items; fees under $10 can be raised by $1.

The limits are effective as of the first of this year. They remain legally in effect until April 30 by which time Congress must authorize an extension of the President's power to impose wage-price controls or they will expire. There is growing sentiment in the Senate and the House to terminate the program.

The regulations in the health field have been under court attack. Nursing homes have won a preliminary legal battle in their suit against the Phase III controls. The American Hospital Association has threatened to challenge the controls in court.

Hospitals were restricted to a 7.5 per cent increase per in-patient stay, with adjustments for volume changes.

Under the final regulations, all physicians must maintain a schedule showing prices in effect on December 28, 1973, which comprises 90 per cent of their revenues, and the subsequent changes and dates. "A conspicuous and easily readable sign" must be posted stating the availability and location of the price schedule. The requirement applies whether or not fees have been increased.

The Council said that physicians and medical laboratories that have not raised charges as allowed in the past will be allowed to apply the unused portion of increase up to a maximum of 5 per cent.

Administration Supports HMOs

President Nixon is enthusiastically endorsing the Health Maintenance Organizations program effort getting underway at the HEW Department, according to federal health officials.

The government is "going all out" to implement the new law "as rapidly as possible," Charles Edwards, M.D., Assistant HEW Secretary for Health, said.

Proposed regulations to carry out the HMO program will be issued by the end of March.

At a briefing of health reporters, Dr. Edwards announced that the director of the HMO program is Frank Seubold who has been serving as Deputy Director of the old HMO office as well as Associate Director of the Bureau of Community Health. Seubold, 51, is a Ph.D. chemist who came to HEW in 1971 after a career in the aerospace industry in California during which he became increasingly involved in space medicine and medical systems management work. ■

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Physicians—The Modern Day Priesthood With an Impossible Task

BENJAMIN B. OKEL, M.D., *Decatur**

Before hearing Benjamin B. Blackburn it will be necessary for you to hear Benjamin B. Okel. Unfortunately, our constitution requires such an address from the incoming president. I shall set the tenor for the coming year by being brief. I have many faults, but verbosity is not one of them.

I would be less than candid if I didn't confess considerable trepidation over assuming this office. John Heard is a tough act to follow. Any of his predecessors would be a tough act for me to follow. I felt a bit like Zsa Zsa's fifth husband who reportedly said, "Don't expect miracles."

I, like most physicians, find the practice of medicine to be increasingly frustrating. We are all thrown into roles we don't like to play. The medical profession today finds itself in a similarly uncomfortable position to that of the clergy in the Renaissance and at the time of the Reformation. In past centuries the priest represented the most important force in the world—the sacred power of God which promised a happier life beyond. Americans today, at least by comparison with past generations, have no firm belief in afterlife. Rather they believe in a heaven on earth through personal identity, human relationships, fame, entertainment and various forms of self-indulgence.

Antimedical Movement

Health is most assuredly necessary to enjoy this worldly heaven. Thus the physician becomes a modern day priest. The impossibility of the task assigned our medical priesthood is painfully apparent. When our profession is found wanting in this imposed role as the new priesthood, an antimedical movement develops. The financial demands of the medical profession become an outrage just as the financial demands of the clerics in earlier times caused similar hostility. We all feel the frustrations of this unsought role and face more dilemmas now than ever before.

The doctor of medicine has always walked a tightrope between undertreatment and overtreatment, between underinvestigation and overinvestigation. He now daily faces situations where it's be-damned if you do, be-damned if you don't. He must cope with third party involvement. Patients no longer have incentives to economize. At the same time physicians receive primary blame for soaring health costs. We are blamed for and are expected to cure problems which are basically social in cause. This analogy between health and heaven is particularly pertinent to the political scene today. Any politician who promises to his electorate health or "the right to health" is practically promising paradise. Considerable courage is required for a congressman or senator to oppose creation of a medical system that guarantees a heaven on earth—particularly if it is billed as being free.

I often feel that physicians today have little more to do with assuring health than priests in the 16th century had to do with assuring his parishioners a place in heaven. Too often after a long comprehensive workup I end up telling the patient in somewhat different words, "You're a fat lazy slob who smokes and drinks too much." I've had smart answers like, "Why should I pay you to tell me that, Doc, when my mother-in-law tells me the same thing for free?"

One Needed Project

Let's return to our own medical society and its role in 1974. My main purpose as president will be to continue the good programs set in motion by my predecessors. John covered these well at our last meeting. I will not list them now. However, to this long list there is one small needed project that I wish to take on.

I think we can improve on physician accessibility in DeKalb County. Too many DeKalb citizens complain they can't get a doctor when they need one or can't enter the system by finding a primary care physician. True many of these are overstated emergencies or distortions of the true situation or simple cases of procrastination. There has been some talk of our county sponsoring a health access station headed by a physicians assistant or an R.N. I am personally skeptical of this approach. I feel that it would create as many problems as it solves. I think we already have the makings of one of the best health access systems possible, namely our DeKalb General Hospital emergency room and our DeKalb County Medical Society office.

Over the next few days you will get a mailing asking for your degree of willingness to take on new patients. This will greatly help Hank and Sherry, so please give it your sincere consideration. I can't believe that most of you can't at times take on new patients.

Launching Tel-Med

There is one other "health access station" our society should launch this year; namely the Tel-Med System. This is a public health information service that has already proved its great value out on the West Coast.

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* Presidential Address delivered January 21, 1974 before the DeKalb County Medical Society. Dr. Okel's practice is at 2193 N. Decatur Road, Decatur, Ga. 30033.

It is a library system of telephone tapes designed to give our patients and the general public preventive health information and advice regarding common ailments, medical misconceptions, and things that cause needless anxieties. It will decrease the trivia that harasses us daily, but more important it will aid our patients in early spotting of serious disease. It will perhaps get some folks to start living right. There are multiple tapes which deal with smoking, alcoholism, drug abuse and obesity—areas that I consider the real American health crisis. Our board has investigated this and I personally feel it could be the greatest public service our society has ever undertaken. There is one small obstacle—money! It will cost something over $20,000 the first year—something less thereafter. I'm so impressed by the potential of Tel-Med that I'm ready to solicit door to door in order to get it launched.

I think we are the best county medical society in Georgia. I *know* we have the best auxiliary in Georgia. I am looking forward to working with Wilma Tillman and Maureen Vandiver in keeping their organization in its usual outstanding place. You will agree our monthly programs last year were superb. The program should again be excellent. I am looking forward to hearing next month "A Comprehensive Review of Renal Transplantation." We will have a panel discussion on osteopathy by osteopaths in March, a talk on acupuncture by an expert in the field in April, and a visit from an I.R.S. special investigator in May. So you see, we go from the arcane to the mundane.

I have appointed two new committees for the coming year. First, a Long Range Planning Committee headed by Dr. Duane Blair will make some effort to formulate policies for problems in the distant future. At our present growth rate our medical society will have 330 members by 1976 and 450 members by 1984. Size alone brings on new problems. Where do we meet? What type program?

New Private Practice Committee

A second new committee is the Private Practice Committee headed by Dr. John Heard. This group will deal with problems directly affecting the private practice of medicine. An example of a recent controversy which would have been handled, at least initially, by this committee was our approach to PSRO's. For the benefit of the few of you who haven't heard of or know about Professional Standards Review Organizations—this is a vast federally legislated system of peer review which hopefully assures that institutional care paid for by provisions of the Social Security Act are necessary, of acceptable quality, and delivered in the most economical setting. This intent sounds good but most experts agree it will likely in the long run cost the government more than it saves. It will be a great irritant to the vast majority of physicians who are conscientiously avoiding abuse and it won't likely really stop the rascals. They have a way of thriving under government programs. The situation is much like a very expensive exterminating service which smells up the house, threatens the safety of your children and generally disrupts your home—all to kill a few roaches—some of which survive and thrive.

I fully support repeal of PSRO laws but I don't know how far we should go to accomplish this. We may be wasting our ammunition on a little monster while a much larger monster looms on the horizon, namely National Health Insurance. Perhaps our guest speaker can enlighten us further but I predict a stepped up campaign over the coming months to adopt a totally comprehensive National Health Insurance program such as contained in the Kennedy-Griffiths bill. Even the supporters of this bill predict it will cost $68 billion per year; its opponents set the sky as the limit.

If enacted in its present form I predict we would be permanently involved in the financial equivalent of another Viet Nam war. I'm not convinced this country needs any National Health Insurance—perhaps catastrophic insurance, but certainly not first dollar no deductible insurance which removes all incentives for conservation of a precious national resource—our American health professionals. That makes as much sense as trying to solve the energy crisis by making gas and electricity free.

From my remarks you might take me to be laissez-faire conservative. Actually I'm less conservative than most of you but I am a realist and a bit of a skeptic when it comes to governmental solutions, particularly in matters related to health. Our U.S. government is very much like the over-treating physician who gives penicillin for every cold, cortisone for every joint ache, and narcotics for every headache. He constantly must treat new problems created by his overtreatment.

Because we in medicine are now inextricably involved in various governmental programs it is quite appropriate that we have an expert on the ways of Washington speak to us. Our distinguished guest speaker tonight could well be introduced by a number of our members in that he has several close friends and loyal campaign workers in our Society. I well remember a chat with Dr. Luther Vinton at a MAG meeting about eight years ago. He then predicted that a bright, handsome young man who had just entered the DeKalb political arena was going to topple the then incumbent democratic congressman. I naturally scoffed at this and stated something to the effect that the Democratic Party had always controlled things in Georgia and always would. Because of Luke's amazing prescience I have asked him to introduce our guest speaker. ■

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Repeal PSRO

Special Issue

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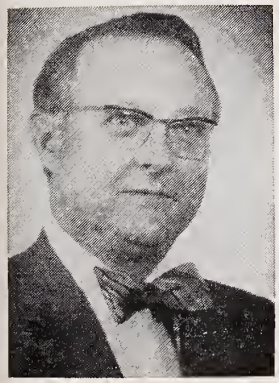
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THE COVER

The simple message of this Special Issue is boldly spelled out on the cover. The "vignette" background suggests the future of medical practice, which may be dark or bright depending on our efforts now. Cover design by Bob Hamill, Atlanta.

president's letter

Special Issue Designed to Inform, to Initiate Action



AS SOME OF YOU MAY recall from earlier issues of the *Journal* and mailings from MAG Headquarters, a special issue of the *Journal* dealing with the single topic of PSRO Repeal has been in the works for some time now. Well, here it is! I would like to spend just a few moments reviewing it with you.

Please be sure to take a minute or two to read the program for the Rally to Repeal PSRO planned for Atlanta on April 7. Mark your calendar *right now* for this most important meeting. We'll have some nationally known figures there to advise us on how to work for the repeal of PSRO.

Let me highlight now a few of the articles and items in this issue. The legal angles are covered by MAG's counsel, Mr. Winston Huff. Representative Ben Blackburn of Georgia's 4th District thinks repeal is possible and says "the PSRO law is not a product of Congressional intent." To let you know what individual physicians and the county medical society can do at their level, this issue includes an article by Bibb County Medical Society's President, John O'Shaughnessey. There are several more informative items that I hope you will find time to read.

Our strength as an organization depends on your being well informed. And, certainly this is the one issue about which we must insure that all our members are knowledgeable. So tell your colleagues to read this Special Issue of the *Journal*. If they didn't get one, tell them to request an issue from MAG Headquarters.

Don't forget April 7 in Atlanta for the Rally to Repeal PSRO.



Charles Emory Bohler, M.D.
President, Medical Association of Georgia

Repealing PSRO—A Legislator's Point of View

THE HONORABLE BEN B. BLACKBURN, M.C., *Washington, D.C.*

Is PSRO REPEAL POSSIBLE?

That question has now become a focal point for the long struggle between defenders of private medicine and advocates of increased government regulation of the health care system.

Is repeal probable? Obviously I cannot answer that, much as I would like to. It is still too early to determine what force can be mustered behind an effort to repeal establishment of innocent-sounding physician committees to review medical standards. Even the title—Professional Standards Review Organization—is one likely to lull potential opponents to sleep.

But is it possible to repeal the law that saddled the medical profession—and its 200 million patients—with PSRO regimentation? Yes, it is possible because it is in the best interests of all people that the law be repealed. I believe the medical profession should work actively toward that goal. Many of us in the Congress are prepared to stand with you.

About the Author



Fabian Bachrach Photo

The Honorable Ben B. Blackburn is a representative from the 4th District of Georgia to the U.S. Congress, having been first elected in November 1966. He serves as a member of the House Committee on Banking and Currency and the Joint Economic Committee.

Mr. Blackburn was born in Atlanta and graduated from Tech High School. He received his B.A. degree in political science from the University of North Carolina and his LL.B. from Emory University School of Law in 1954. He served in the U.S. Navy during World War II and the Korean Conflict and worked for two years on the staff of the Attorney General for the State of Georgia before joining the firm of Peek, Whaley and Blackburn.

Reviewing a Truism

We have all heard the "truism" that it is impossible to repeal an act of Congress after it has become law. But the truism isn't always true. It requires a greater effort to repeal a law than to pass one and it requires a stronger motivation to stir a new fight over a battle which has already been lost once, but the House of Representatives is responsive to voters.

That is the textbook definition of how our system is supposed to work—and it works exactly that way.

On any bill, whether a new proposal or an existing law, the ultimate action of the Congress will be what most of the voters want it to be—or what members believe the voters want. Congressmen who are indebted to some special interest group, perhaps because of substantial campaign contributions of time or money, cannot ignore the fact that their first obligation is to the voters who elect them.

That, of course, is the political strength of organized medicine and the people they serve. Those people—the millions who pull the voting machine levers and mark the ballots—are also your patients. Almost every voter in America will have a face-to-face talk this year with his physician. If they become convinced—as you are and I am—that PSRO restrictions will prevent you from giving them the best care possible, repeal will suddenly become a very high-ranking item on the Congressional agenda.

Congressional Intent

In considering whether repeal is possible—and whether you want to make it a major item on your own priority list—you must keep in mind that the PSRO law is not a product of Congressional intent. While it is always difficult to repeal any law on which the members of Congress have already made a firm decision, the difficulty is not so great when many Congressmen didn't fully understand the full

ramifications of a bill at the time it was presented to the floor.

The legislative system, sensitive and responsive as it is, has its flaws, too. The PSRO law that was enacted by the 92nd Congress was a result of one of those chinks in the process.

H.R. 1 was a lengthy and complex series of amendments to the Social Security law. But as it was debated and studied in the House of Representatives, H.R. 1 had no PSRO provision. PSROs were never mentioned in the House debate, nor discussed in testimony by outside witnesses. Although the plan had been discussed in the Senate, most members of the House had never even heard the expression "PSRO" and would have had no idea what the letters meant.

After H.R. 1 was passed by the House, the Senate, in its consideration of the bill, added the PSRO section with little discussion or public awareness. When the bill was referred to a conference committee to iron out the differences in the House and Senate versions, members of the House delegation concentrated on the variations in the hotly debated sections that had drawn public attention. Little notice was given to the innocuous new section with the innocent-sounding title.

"But is it possible to repeal the law that has saddled the medical profession—and its 200 million patients—with PSRO regimentation? Yes, it is possible because it is in the best interest of all people that the law be repealed."

Finally the bill came back to the House, with the PSRO amendments buried in a small booklet full of fine print. Again the debate raged around the portions which had received the greatest attention in the original House discussions of the bill. When the legislation was finally accepted by the House, Public Law 92-603 (the former H.R. 1) had a few items included under Section 249F in the back of the book. Most Members of Congress remained unaware the section was in the law.

Yet it is that little-noticed language—accepted with no testimony and no debate in the House of Representatives—that would require preadmission hospital certification, adherence to computerized "norms," and release of previously confidential patient information.

There seems to be little disagreement in the medical profession that the PSRO section is a serious threat to the traditional doctor-patient relationship and the confidentiality so necessary to that relationship. There is little doubt that most doctors want the law to be repealed.

Loss of Confidentiality

The threat to doctor-patient confidentiality seems to me to be sufficient motivation to launch a serious effort in that direction. Certainly no member of the society we live in is in a better position than you are to accurately predict the ultimate effect of controls over the decision-making processes which are the key to good medical care. And no citizen need merely shrug his shoulders and say, "It's no use fighting city hall." Not only do you have a proper motive to challenge the federal establishment—to seek the repeal of a truly bad law—but you also have the political advantage (access to your patients) and the motivation (an oath to do your best for each of your patients).

Already many members of Congress have let it be known they will work to attempt to repeal the law. In fact, nearly 40 Congressmen—myself included—signed a public statement to that effect. A number of bills to repeal PSRO have been introduced in the House of Representatives, and Senator Carl Curtis has sponsored similar legislation in the Senate.

With this expression of legislative support, there is some grounds for optimism. Each of us who works in public life must make the effort to at least try to accomplish what we believe to be right. Every member of Congress sometimes sponsors and works for legislation which he recognizes may have little chance of passage, but which he believes to be in the best interests of the people. It is the cause, not the chance of success, that determines what effort we must make.

Repeal Is Important

I personally believe there is a decent chance to repeal the PSRO law, and I believe repeal is important. Already other legislation has been drafted that would extend PSRO jurisdiction to all health care. If the law is not repealed, it may soon become the mechanism by which extensive changes are wrought in the practice of medicine, with diagnosis and treatment mandated by pre-printed computer forms and regulation booklets.

I do not consider the repeal of PSRO to be one for the benefit of the medical profession. The repeal of PSRO is a campaign on behalf of the patient, who is also the consumer, the taxpayer, the voter, the average citizen.

Together—you, your patients, and we in Congress—can make the system work. The American Medical Association has stated repeatedly that PSRO is "bad law" and has now stated that it is in the best interests of the American people that the law be repealed. I believe we should try to do just that. ■

Support for Repeal Grows in Congress

At the present time there are 18 bills pending in the Congress calling for the outright repeal of PSRO —17 in the House and one in the Senate. Statistically the situation breaks like this:

House of Representatives

(a) Seventeen bills introduced and referred to the Ways and Means Committee;
(b) There are 28 sponsors of these 17 bills;
(c) The 28 sponsors come from 17 different states;
(d) The sponsors are by party affiliation 5 Democrat and 23 Republican.

United States Senate

(a) One bill pending in the Senate Finance Committee, sponsored by Carl Curtis, Nebraska, Republican.

The sponsors of the House Bills are:

Alabama	Nichols	H.R. 11946
Arizona	Steiger	H.R. 11705
California	Rousselot	H.R. 11719
	Ketchum	H.R. 12407
	Talcott	H.R. 11946
	Veysey	H.R. 11946
Florida	Lehmann	H.R. 11444
Georgia	Flynt	H.R. 12256
	Mathis	H.R. 12353
Idaho	Symms	H.R. 11444, 11635
Illinois	Crane	H.R. 11689
	Derwinski	H.R. 11584
Indiana	Hudnut	H.R. 11444
	Landgrebe	H.R. 11444, 11718
	Myers	H.R. 12030
Iowa	Scherle	H.R. 12259
Louisiana	Rarick	H.R. 9375, 11444, 11532, 11946, 12256
	Treen	H.R. 11444
Maryland	Bauman	H.R. 11946
	Holt	H.R. 11946
Mississippi	Lott	H.R. 12256
New York	Kemp	H.R. 11825
Ohio	Ashbrook	H.R. 11394
Oklahoma	Camp	H.R. 11946
Texas	Collins	H.R. 11444
Virginia	Daniel	H.R. 11532
	Parris	H.R. 12256
	Whitehurst	H.R. 11444

PSRO: An Analysis of the Law

J. WINSTON HUFF, *Atlanta*

LATE IN 1972 CONGRESS enacted and President Nixon approved Public Law 92-603 which contains many amendments to the Social Security Act. Among these many amendments the most notorious by far is that one requiring the establishment of Professional Standards Review Organizations (PSROs) to review services provided under Medicare and Medicaid by health care practitioners and institutions. The portion of the law dealing with PSROs is too lengthy to be reviewed in complete detail here. The purpose of this article is to set forth the highlights in the hope that Georgia physicians will have a better understanding of what is involved. It should also be pointed out that no regulations (other than area designations) have been issued by the Department of Health, Education and Welfare (HEW). Throughout the PSRO law reference is made to regulations which will be issued by the Secretary of HEW, Mr. Weinberger, and these regulatory interpretations of the law may change or conflict with your author's view of what the law says.

About the Author



J. Winston Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, Eleventh Floor Citizens and Southern National Bank Building, Atlanta, Ga. 30303. Mr. Huff is a native of West Point, Ga. who received his A.B. degree from the University of Georgia in 1941 and LL.B. from Yale in 1947. He joined the law firm with which he is still associated in 1948. Mr. Huff is past president of the Atlanta Legal Aid Society, board member and past president of Traveler's Aid.

What Is a PSRO?

The Secretary of HEW is required, no later than January 1, 1974, to establish "appropriate areas" within which PSRO's will be set up. Secretary Weinberger, on December 20, 1973, issued a proposed regulation setting up PSRO areas throughout the United States. Georgia was divided into three such geographical areas. Some states were designated as a single PSRO area, and a number of states were split into multiple areas. This proposed regulation has not yet become final.

The Secretary is also directed "at the earliest practicable date" to enter into an agreement with a "qualified organization" in each PSRO area under which this organization will be conditionally designated as the PSRO for that area. If this PSRO proves itself capable and qualified in handling the job, then the Secretary will formally designate it as the PSRO for that particular area and will enter into an agreement with it for PSRO services. All agreements may be terminated by HEW if the PSRO does not substantially carry out its functions. The PSRO itself may terminate the agreement by giving advance notice to HEW.

Only a "qualified organization" can become a PSRO, which the law defines as follows:

A. An organization (i) which is composed of licensed doctors of medicine or osteopathy practicing in the PSRO area, (ii) which is a non-profit professional association, (iii) the membership of which includes a substantial proportion of all physicians in the area, (iv) which is organized so as to make available professional competence for peer review, (v) the membership of which is voluntary and open to all licensed doctors of medicine and osteopathy in the area without any requirement of membership in or payment of dues to any organized medical society, and (vi) which does not restrict eligibility of any member for service as an officer of the PSRO or for assignment as a reviewer;

or

B. Some other public, non-profit private, or other organization which HEW determines to be competent and suitable.

Doctors of medicine and osteopathy (see paragraph "A" above) are given the first chance to set

up a PSRO in their area. Until January 1, 1976, the PSRO for any particular area must be composed of licensed MDs and DOs. However, if there is no such organization on and after January 1, 1976 which in the Secretary's opinion is willing and capable, then the Secretary may designate an organization described in paragraph "B" above. There is a further provision requiring the Secretary, until January 1, 1976, to give notice to all MDs and DOs in an area before he signs a PSRO agreement. If more than 10 percent of these physicians object to entering into this agreement, then the Secretary must take a poll in the area. If more than 50 percent of the doctors responding to the poll indicate that this organization is not representative, then the Secretary can not enter into the agreement with that PSRO. After January 1, 1976, this physician approval will not be necessary.

Duties and Functions of a PSRO

PSROs can review only health care services provided by or in institutions, unless a particular PSRO requests the Secretary of HEW that it be permitted to review other health care services and the Secretary approves this request.

The duty and function of a PSRO is defined as the responsibility for the review of the professional activities of physicians and other health care practitioners as well as institutional and non-institutional providers of services and items to Medicare and Medicaid recipients, and, in that connection, to determine whether the services and items:

A. will be provided only when and to the extent medically necessary;
B. will be of a quality meeting professionally recognized standards of health care; and
C. will be supported by evidence of necessity and quality in such form as the PSRO requires.

Also, it is the duty of each health care practitioner, in ordering or authorizing care to be provided by another, to exercise his "professional responsibility" to assure that the services will be provided only when and to the extent medically necessary and will be of a quality which meets professionally recognized standards.

The above constitute the "criteria" which must be met for the service or care to be paid for under Medicare and Medicaid.

Each PSRO is given the right to determine in advance whether the proposed service meets the above criteria in instances of (i) elective institutional admission, and (ii) extended or costly courses of treatment. Each PSRO must determine and publish the types and kinds of cases which will require this pre-admission certification.

The PSROs are required to maintain and review patient profiles and profiles with respect to each physician-provider to determine that the care and services rendered are consistent with the above-stated criteria.

The law requires that each PSRO encourage participation of all physicians, rotate membership on review committees, provide broad representation on committees of various types of practice and utilize medical periodicals to publicize its activities. The PSRO is authorized to undertake the review process "before or after" (or both) the rendition of the service. It has the right to examine the records of any practioner or provider and to inspect any facility of any practitioner or provider in which care is rendered or services provided.

The agreement entered into between HEW and the PSRO must contain requirements that the PSRO will perform its functions as required by the law and by such regulations as HEW issues and collect such data and keep such records as the Secretary may require. The Secretary must have access to these records.

HEW is authorized to pay with government funds the expense of any PSRO in carrying out its duties and functions under the agreement.

Who May Perform Peer Review

Only licensed doctors of medicine or osteopathy may make a final decision in the review of other doctors of medicine or osteopathy.

Only physicians having active staff privileges in at least one hospital in the PSRO area can review hospital care. A physician should not be responsible for, although he may participate in, the review of care and services of a hospital on whose staff he serves. If an already existing in-hospital review committee demonstrates to the PSRO in its area that this committee has the capacity to effectively review the activities in that hospital, then the PSRO shall utilize the services of and accept the findings of that hospital review committee.

A PSRO is authorized "to the extent necessary or appropriate" to make arrangements for the involvement and services of other practitioners or specialists in the various areas of medicine (including dentistry) or other types of health care.

Norms of Health Care Services

As "principal points" of evaluation and review, each PSRO must apply "professionally developed norms of care, diagnosis and treatment based upon typical patterns of practice," including typical lengths of stay for institutional care by age and diagnosis. With respect to any particular illness or condition these norms must include the types and extent of services which are considered within the "range" of appropriate diagnosis and treatment consistent with "professionally recognized and accepted" pat-

terns of care and the type of health care facility in which the services can be most economically provided. These norms must be "in accordance with" regulations of the Secretary of HEW.

The National Professional Standards Review Council (described below) is required to prepare and distribute "appropriate materials" containing the "regional norms" (not defined) which must be utilized. It is not absolutely clear whether the National Council may override the norms established by a particular PSRO, but it does appear very possible. The regulations, when issued, will probably have something to say about this.

Once the norms are established, each PSRO must use these norms in evaluating whether the criteria (described in paragraphs "A," "B" and "C" above) are met.

Every PSRO (in accordance with HEW regulations) must specify the time after admission of a patient at which the physician must certify that further in-patient care is necessary and must require the physician to furnish such information as will enable the PSRO to evaluate whether further institutional care is necessary. The particular time at which any such physician certification will be demanded is to be based on the norms of care and treatment data developed with respect to length of stay of patients having various illnesses and conditions and requiring various types of services. The law says this particular time of certification should not "usually" be later than the 50th percentile of lengths-of-stay for patients in similar age groups with similar diagnoses.

Review: a Requirement of Payment

No Medicare or Medicaid funds may be used to pay a claim which has been disapproved by the PSRO. Notice of disapproval must be given to the provider.

Hearings and Review

If there is no statewide PSRO council (described below) a beneficiary or a provider is entitled to a reconsideration by the PSRO of an adverse decision. If (there being no statewide council) the controversy involves at least $100, the beneficiary or provider shall be entitled to a hearing before HEW personnel.

If there is a statewide council the appeal mechanism is first a rehearing before the PSRO and, if the controversy involves at least $100, then a review by the statewide council.

If the controversy involves at least $1,000, court review is available.

Obligations of Providers Penalties, Hearings

It is the "obligation" of each practitioner and provider to assure that the services or items will be furnished (i) only when and to the extent medically necessary; (ii) will be of a quality which meets professionally recognized standards; and (iii) will be supported by evidence of medical necessity and quality as required by the PSRO. Further, it is the obligation of any practitioner in ordering or authorizing services by any other person to assure that the services or items will be provided only when and to the extent necessary and will be of a quality which meets professionally recognized standards.

Each physician, hospital, or other provider has the obligation "within reasonable limits of professional discretion" not to take any action authorizing any individual to be admitted as an inpatient in a facility unless (i) inpatient care is necessary or (ii) the care cannot be provided more economically in a different type of facility, or no such other facility is available.

If a PSRO determines that any practitioner or provider has violated the above obligations, the PSRO must report this fact to the statewide council (if there is one) with recommendations for appropriate action. The statewide council must then transmit the report to HEW with any additional comments it desires.

The law requires, however, that the PSRO give reasonable notice to the practitioner or provider and an opportunity for discussion before the report is transmitted. The same is true where the PSRO denies a claim or asserts some other violation.

If the Secretary of HEW finds that the practitioner or provider has failed in a "substantial number of cases" to comply with the above obligations or has "grossly and flagrantly" violated these obligations, the practitioner or provider may be permanently barred, or suspended for a period of time from receiving Medicare and Medicaid reimbursement. Also, the Secretary may require, as a condition of continued eligibility, that the provider pay to the federal government the lesser of an amount not exceeding the cost of the medically improper or unnecessary services or $5,000. These are the only sanctions contained in the PSRO law, but are not the exclusive penalties which may be imposed. There are other penal statutes which impose other penalties.

The Secretary's determination in these matters becomes effective after reasonable notice to the public and the provider at a time set by him. If dissatisfied, the practitioner or provider may ask for a hearing and, after that, for judicial review.

Statewide Review Councils

If a state has three or more PSROs (which Georgia will have unless the proposed regulation is changed) the Secretary of HEW must establish for

that state a "statewide professional standards review council." It is the duty of the Secretary to appoint the members of this council as follows: (i) one representative from each PSRO in the state; (ii) four physicians, two designated by the state medical society and two by the state hospital association; and (iii) four persons knowledgeable in health care as representatives of the public, at least two of whom shall have been recommended by the governor.

It is the duty of the statewide council, under regulations of the Secretary, to coordinate the activities of the PSROs in the state, disseminate among these PSROs information and data, including assistance in the development of a uniform data gathering process and operating procedure, to assist the Secretary in evaluating the performance of the PSROs within the state, and, where a PSRO must be replaced, to assist the Secretary in finding a qualified replacement PSRO.

The statewide council will be advised and assisted by an "advisory group" of not less than seven nor more than eleven persons drawn from representatives of health care practitioners (other than physicians) and hospitals and other health care facilities. The Secretary by regulation will provide the manner in which the members of this advisory group will be selected.

The Secretary is authorized to pay the expenses of the statewide council and the advisory group.

National Review Council

The PSRO law establishes a National Professional Standards Review Council consisting of eleven physicians appointed by the Secretary of HEW. These members are to be physicians of recognized standing and distinction in the appraisal of medical practice, a majority of whom have been recommended by national organizations representing practicing physicians. The membership shall also include physicians who have been recommended by consumer groups and other health care interests. It is this council's duty to advise the Secretary of HEW, provide for the development and distribution of information and data to statewide councils and PSROs, to review the operations of statewide councils and PSROs in order to determine effectiveness and performance and to make studies in order to recommend to the Secretary and to Congress additional measures to accomplish the purposes of the law.

Confidentiality

Any data or information acquired by a PSRO must be held in confidence and shall not be disclosed to anyone except to the extent necessary to carry out the purposes of the law or, under regulations by the Secretary, to assure adequate protection of the rights of patients, practitioners and providers. Violation of this provision is punishable by a fine of not more than $1,000 or imprisonment for not more than six months, or both.

Protection from Liability

No person who provides information to a PSRO can be held criminally or civilly liable for having provided such information unless the information is unrelated to the performance of the duties of the PSRO or the information is false and the person giving the information knew, or had reason to believe, that the information was false. This seems intended to protect against suits for libel and slander.

Further, the law affords criminal and civil immunity to members or employees of a PSRO (or a person who furnishes professional services to a PSRO) in the performance of any duty or activity authorized or required by the PSRO law. This immunity would not be available where the person involved is shown to be motivated by malice.

Finally, the law states that no practitioner or provider shall be civilly liable on account of any action taken by him in compliance with the professionally developed norms being applied by a PSRO. This exemption, however, applies only if the action taken by a practitioner or provider was in the scope of his profession as a doctor of medicine or osteopathy or, in the case of a provider, in the exercise of furnishing health care services. Further, it must be shown that the person exercised due care in all professional conduct taken or directed by him in compliance with the norms. The Senate Finance Committee report on this section of the Act says that it is the intent of this provision to "remove any inhibition to . . . the following by practitioners . . . of standards and norms recommended by the review organization." ■

The Downside Risk

W. DAN JORDAN, M.D., *Atlanta*

BEFORE ENTERING INTO A FULL discussion of PSRO law, let's pause and consider a principle for a moment. I will use an analogy in an attempt to prove my point.

Suppose an investment broker approaches you to purchase stock in a new venture. He will proceed to paint beautiful pictures of the new company, describing an innovative product, sound management and exciting marketing concepts that will make this product overwhelm the public. He will explain how the returns on your investment will be plowed back into the company initially but within a few short years the return on your investment will rapidly increase and then you will have a comfortable nest egg for retirement or college education for your offspring. He winds up his spiel by producing a short legal document for you to sign committing you to a significant financial expenditure.

With all these stars before your eyes and pen in hand, you recall an admonition from old grandpa—"What about the downside risk?" The broker responds with several sentences describing how any company can fail, but really, the need is there, we have sincere people working in this company, and this is the perfect opportunity to get in on the ground floor. You persist with your questioning and finally the broker reacts, chastising you for being a pessimist, for painting a black picture about the future, for being an alarmist, and finally drives you to your knees by saying—"If you don't buy this, then your neighbor will and you will be out in the cold." You struggle back to your feet and thank the broker for his time, requesting him to call you back in a week, and gently push him out the door, remembering all the time what your old grandpa (who died at 110 after being hit by a car) said—"What about the downside risk?"

Now that you (the reader) are convinced that I am an alarmist, let's talk more about the downside risks of PSRO.

1. Cost. Since we have been talking about money, let's talk about the cost involved with PSRO. Medical care costs have obviously greatly increased in the past decade, the overwhelming percentage of *cost increases* have been in areas where the physician does not exert control. Will implementation of PSRO serve to control costs? Setting aside the amounts necessary to crank up the bureaucratic mechanism, the only methods available in PSRO law to control costs is by means of denial of benefits to the beneficiary. Since the MD's fee represents only 15 to 20 percent of medical expenditure, the majority of the denials will rest on the shoulders of the patient. Aside from the moral aspects of selling an insurance policy that carries the prerogative of retroactive, concurrent, or prospective denial (decided at the whim of the insuror), it would appear that PSRO law could be used to control (or lower) costs.

Speculations as to cost have abounded but one for thought is that quoted to the MAGNET conference in November 1973, by the chairman of AMA's Task Force on PSRO. He reported the initial cost of PSRO (including start up operations) at $500 million with hopes of saving $200 million. I read this as a $300 million deficit. How about you? Operating at a deficit is certainly not new for government. Perhaps the reader is aware of the fact that out of some 700 different enterprises in which the federal government is involved, only one has operated at a profit. Which one is that? The Panama Canal—and it appears they are paving the way to divest themselves of even that.

Past events would suggest that government does

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not have the capability of operating any enterprise (including an insurance company) without incurring a deficit. I fail to see how we can expect PSRO to be anymore effective in controlling costs than has any other government activity.

2. Confidentiality. The spectre of invasion of privacy has certainly risen in the minds of the public. National headlines have made this issue important in all phases of our lives. With the implementation of PSRO will come the development of provider profiles and patient profiles. There has been considerable discussion about the elaborate mechanisms involved in the computer storage of all this data. Regardless of the protections, once the information is recorded, it then becomes available for retrieval. The next question would be "Who controls the retrieval mechanism?" I recall a legal axiom based on Supreme Court decisions stating—Whatever the federal government subsidized, it will have the right to control. That seems pretty clear to me.

Apart from the above there is another issue. PSRO law provides the mechanism for inspection of office records under the guise of determining whether federally subsidized patients are being treated differently. Of course, even though the authority is there, they would never use it. (That's what Nixon said about wage and price controls.) We might argue whether confidentiality is completely gone, or maybe only partially gone. It's not a question of whether you lost, it's only how much you lost.

3. Quality of care. This is something that is extremely difficult to measure. We, as MDs, feel that it may be possible to review an individual case and decide if that patient received good care, but across the board application is much harder. We hear much conversation about deterioration of care, but I think this refers to our subjective impressions about nursing care. What yardsticks can be used to evaluate this? Reportable contagious diseases are probably valid, but how about life expectancy rates, infant mortality figures, death certificate statistics? Unfortunately, we are left with generalities and this makes discussion rather difficult. It would appear that in the minds of the world's physicians (our peers?) we have developed the best system available. At least they have been coming to our country for training, to practice, and to receive care.

Perhaps the most worrisome aspect concerning quality care is the establishment of parameters on which care is to be judged. I believe the main concern in this area is that care delivered will seek that defined level and then stagnate. Personally, I feel that the strength of our system has been the so called "cottage industry" effect, where each physician is working toward the *best* care possible, rather than toward a defined level. Even if an efficient method was available, it would require at least five years of PSRO activity to provide the information either way. Can we afford that downside risk?

Another aspect of quality of care is the apparent possibility of increase in malpractice suits. The "hold harmless" clause of PSRO law is legally questionable on its surface, but I suspect several court decisions would be necessary to determine its effect. Meanwhile, what will happen to the physicians who deviate from the proscribed methods? The lawyers have stated that they feel the establishment of a set of parameters would lead to a rapidly increasing number of legal actions. The simple effect would be more defensive medicine (increasing costs), rising malpractice rates (increasing costs), and a standardization of care delivered (good or bad). Can we afford this?

4. Rationing. Rationing, a forgotten word, but now being revived—could it apply to medical care? There are three elements that lead to rationing. The first is increasing or unlimited demand, the second is a limited supply, and the third is power and authority to control the supply.

The institution of Medicare-Medicaid has fueled the demands for care with little or no limitation on the beneficiary. This was done suddenly without a concomitant increase in the available supply. The increasing demand and utilization led to a dramatic increase in expenditure. Now that the scenario is written—enter PSRO from stage left. Within PSRO lies the power and authority to deny benefits. Regardless of the objectives of the law, the potential is there. If the government is faced with an inability to keep down the expenditure, how is it going to regulate the situation? As the controls are imposed, at what point is it called rationing? Is this very real possibility a downside risk?

5. Morale. An almost impossible effect to describe—much less measure. The imposition of controls over the practice of medicine under the delusion of controlling costs, but not physicians, is unrealistic. Just the passage of the law resulted in one man closing his office. The appearance of premature retirement, transfers into institutional work, and the psychological deterrent to aspiring students are recognizable events, but counting them is beyond our abilities. This incalculable effect would likely be spread over all other aspects of the law, removing the foundation of responsibility much as is done in any bureaucracy or institutional activity.

This might be the most deadly of all the deleterious effects yet the most difficult to define—a risk almost better not mentioned but its impact so pervasive that it cannot be ignored. I will leave this element of risk to the reader's judgment.

All of the above leads me to believe that we do face the possibility of a substantial loss in overall

medical care with this new venture. We cannot deny that the venture (law) exists, and we should not. Perhaps we can gain enough control to modify it and make it more palatable. Perhaps we cannot.

If, in fact, we feel that the advantages of PSRO are so great as to far outweigh the potential bad effects, then it is time to proceed with the law. MAG, in concert, has stated that PSRO is an ill-conceived law, and will prove detrimental to the patient, physician, and the government. I agree. I feel the downside risk is too much to bear. If this be so, simple nonparticipation will not be enough. Our patients are at stake. For their protection only repeal of the law will suffice to remove the danger. ■

PSRO—A Second Look

L. C. BUCHANAN, M.D., *Decatur*

IN THE MAY 1973 ISSUE of MAG *Journal,* in an article entitled, "P.S.R.O.—Placebo or Therapy?" the Professional Standards Review Organization statute was briefly discussed. We editorially asked some questions regarding the feasibility of the Law, whether it could attain the stated objectives of cost control and improved quality of care and whether we, the practicing physicians of Georgia, should seek to be designated as the actual group to perform the PSRO functions in our state. It was therein pointed out that intelligent consideration of, and answers to, many of these questions must await the issuance of administrative regulations and operational guidelines by the HEW Secretary, to whom the law gives horrendously far-reaching powers over the practice of medicine. The only formal regulations officially issued so far deal with 182 geographic area designations throughout the nation and prescribes that Georgia shall be divided into three areas each with a separate PSRO. This division of Georgia was opposed by MAG prior to the Secretary's action, was discussed personally by MAG leaders with Mr. Weinberger, in the presence of Senator Talmadge who strongly supported our request, and has been vigorously protested by MAG membership and many friends of MAG since the announcement appeared in the *Federal Register* on December 20, 1973. This three area designation may yet be reversed by the HEW Secretary.

About the Author



L. C. Buchanan, M.D. serves as vice speaker of the MAG House of Delegates and is a member of the Committee on PSRO. Dr. Buchanan is also a member of the Association's Insurance and Economics Committee, councilor from the DeKalb County Medical Society, vice chairman of the Board of the Georgia Medical Care Foundation, a GRMP advisor from District 4 and a member of the nominating commission for medical doctor appointments to the Board of Human Resources.

The Georgia native was graduated from Emory University School of Medicine. Dr. Buchanan's practice in surgery is located at 374 W. Ponce de Leon Ave., Decatur, Ga. 30030.

Good News and Bad News

The MAG House of Delegates in special session in Atlanta, December 14-15, 1973, voted overwhelmingly to work for repeal of Section 249-F, P.L. 92-603, and resoundingly defeated attempts to reverse or weaken that stand. If, then, one assumes that the practicing physicians of this state believe that PSRO is a bad law, that it may *operate* but that it will not *work* (there *is* a difference), and that we are bound together as a strong majority to vigorously work for its repeal—then there is both—"good news and bad news."

Since our last editorial a number of factors relating to the PSRO Law have surfaced and been under study and evaluation by MAG. Looking first at the "bad news," one could list the actions of HEW Secretary Weinberger in disregarding the reasonable MAG request, presented in person, that Georgia be designated a single statewide PSRO area. That request was based on documented past performance in cutting Medicaid Georgia costs by more than $1.2 million annually for each of the past three years; the

record of an efficient and proven statewide peer-review system; the demonstration of an on-site nursing home utilization review program which is being sought as a model for other states, etc. The request was supported by Senator Talmadge, Representative Phil Landrum, Georgia Hospital Association, Georgia Nursing Home Association, insurance carriers and others. All of this was apparently ignored in HEW area decisions and again raises serious questions as to whether the mammouth HEW bureaucracy and its leaders have any real intent to work in good faith with physicians to accomplish the stated goals of decreasing costs and improving quality of medical care.

It is "bad news" that Secretary Weinberger, ignoring previous massive protests to proposed requirement of pre-admission certification, did proceed to announce that such a program would be implemented. It is certainly "good news" that a nationwide storm of protest capped by the AMA announcement that it planned to sue him, was followed by Mr. Weinberger's hasty withdrawal of plans for implementing that provision of the PSRO Law. We will hear of this matter again—it has only been postponed for the present.

Although it is no surprise, another "bad news" item was the public announcement by Secretary Weinberger that, "the PSROs would monitor the quality of medical care under the administration proposed National Health Insurance program presented by the President in the State of the Union Message. The combination of PSRO and universal National Health Insurance is, in the opinion of this writer, socialized medicine in about the most expensive and unwieldly form conceivable.

If not "bad news," it is at least highly frustrating to recognize that the AMA Board of Trustees still has not proceeded to disseminate to the public the deleterious effects of the PSRO Law as directed by the House of Delegates at the June 24-28 annual convention. Furthermore, at the December 1973 Clinical Session in Anaheim, California, the House of Delegates took a new direction and expressed strong sentiment that—"the best interest of the American people, our patients, would be served by the repeal of the present PSRO legislation." This action has been officially judged by the Board of Trustees to be, "an expression of opinion and not a charge to (AMA) officials with immediate and intensive efforts to seek repeal." In a PSRO position paper issued at its January 24, 1974, meeting, the Board of Trustees expresses its judgment that it is to continue to work to "achieve whatever rules, guidelines and amendments possible." Trustee James H. Sammons, M.D., says, " . . . in the future I hope the House . . . will be very explicit if indeed it wants action." Time is growing short but maybe the House will be a little more explicit in future direction it gives the Trustees.

Good News

On February 6-7 a group of MAG leaders returned to Washington with the express purpose of apprising the Georgia Congressional Delegation of the mandate it had received from MAG House of Delegates in December, *viz.,* that MAG was overwhelmingly committed to an all-out effort to work for repeal. Your officers agreed that our senators and congressmen deserved to learn of the House action and of MAG's intent to embark on a program of physician and public education about PSRO and what we consider will be the deleterious effects of implementation on our patients. We all agreed that our congressmen, many of whom continue to lend us considerable assistance and support, were entitled to learn of our intent from MAG and not belatedly via the lay media and from the public. Your officers gained audience with one senator and with eight of our 10 representatives. The results of these conferences were very encouraging. One Georgia representative had already introduced a bill to repeal PSRO. Another is a co-sponsor of a different House Bill having the same purpose. Two other Georgia representatives were among approximately 40 congressmen signing the letter advocating PSRO repeal which was presented to the AMA House in Anaheim last December. At least six of our 10 congressmen stated to us that they would support efforts to repeal the law and another that he would work with us to amend the law appreciably.

As of February 7, 1974, a total of 18 bills had already been introduced in the House of Representatives to repeal PSRO.

At its January meeting, MAG Council appropriated $60,000 to be used in 1974 solely for the purpose of working for PSRO repeal. Executive Committee of Council has authorized the engagement of a professional public relations firm to develop and assist in MAG efforts to work for repeal.

So, many factors are at work; whether outright repeal can be accomplished, or whether "repeal by amendment" will be a more prompt and effective *modus operandi* is at present indeterminate. The legislative process is slow. It is clear to this writer that the provisions of the Law cannot *SAVE* money nor improve quality of medical care. The Law will not increase accessibility of care; indeed, it can only decrease physician man-hours available for patient care, violate patient-physician confidentiality, stifle innovative and individual patient care, and accelerate growth of the national bureaucracy.

Brother, if you can't tell which way the wind is blowing—You ain't raking leaves. ■

What Can Be Done by a County Medical Society in Order to Help in the Drive to Repeal the PSRO Law?

W. JOHN O'SHAUGHNESSEY, JR., M.D., *Macon*

WHAT CAN BE DONE by a county medical society in order to help in the drive to repeal the PSRO law?—A good question! The question really should be: "How does the county medical society get the community to back the physicians in areas which they feel important?" I offer these thoughts.

No patient is going to do any favors for a physician unless one of two conditions exist. Either they do it for friendship reasons, feeling that they are obligated, or they feel they also will benefit by backing the physicians and will ultimately be doing it for personal reasons.

Render Services to the Public

Most patients feel that when they or their insurance company pay the bill for physician's services they squared the issue and thus are not obligated anymore—quite a logical position. However, when doctors render services to the public over and above the direct services to the patient, the individual feels obligated to the profession itself and will thus help. This is where the County Medical Society is useful. For example; the Bibb County Medical Society has had its members serve the public in many ways, such as performing free physical examinations for all local high school football and basketball teams. The doctors help with Explorer Scout programs; they render medical care to children in orphanages; attend sport contests as team physicians and treat injured players and serve on drug abuse programs, YMCA and YWCA activities, diabetic camps, etc.

They appear frequently on regularly scheduled television and radio interview programs to bring timely information on varied subjects of a general medical nature such as home treatments, disease discussions and make efforts to keep the public informed about new medical programs and services rendered by the local hospitals. In the past two years, our Medical Society has done a good job in constantly supplying the public with information to prove that the local physicians are responsive, community-minded men and women and thus they dispel the attitude that doctors are heartless, self-centered and disinterested in affairs outside their own practice. I think we are doing a good job in this regard and feel we will have obligated a significant portion of the local population and thus will be able to get their assistance in this fight against PSRO.

I am sure that most of the medical societies are doing as many worthwhile services as we are, but if they are not beating their own drums about it, I suggest they start immediately. We send copies of our newsletter and meeting agenda to the local press, television and radio stations and welcome their attendance at our meetings to show that we are not fighting any battles or conducting any activities which we are ashamed of. I feel all this groundwork will pay off when we go actively before the public to seek support for repeal of PSRO.

Helping Us Helps Themselves

We also wish to obtain support from individuals by convincing them that to help us is to ultimately help themselves. This is primarily with the point that

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the PSRO will require so much physician time, the doctor will not be able to see as many patients as before and will have less time to spend with each individual patient. An individual is indeed in a frightening position when he or his loved one is sick or in pain and cannot find someone who will give them relief. In desperation, he goes to an Emergency Room to seek services from a physician who he knows nothing about and he feels uncertain because "he is not my doctor." Even though the medical treatment is usually excellent, the patient does not have preconceived faith in the doctor, thus he is not as reassured as much as he would like. Thus, this campaign must be run on a basis of public support supplemented by physicians' support. The public is justifiably obligated to the medical profession for its many donated services and failure to support those doctors will result in poorer medical care for the patient.

As to the specific methods to conduct this campaign, I suggest the following:

1. Have posters made to go in the lobby of all hospitals and all doctor's offices telling the patients the disadvantages of PSRO.

2. Select a PSRO committee from society members whose duty it is to monitor the circulated data on PSRO and regularly feed it to the news media through monthly press releases and through regular "Letters to the Editor" suggesting new complications the program will cause if it is put into effect.

3. Have bumper stickers printed for the cars of the physicians and their office help: "REPEAL PSRO—KEEP YOUR DOCTOR WORKING FOR YOU RATHER THAN THE GOVERNMENT"; "KEEP THE DOCTORS INTERESTED IN PATIENTS—NOT GOVERNMENT COMMITTEES."

Most people still don't know anything about PSRO, but they will ask questions after seeing these bumper stickers.

4. Have small notices printed to be included with the mailing of your statement asking your patient to write to the appropriate Congressman in opposition of PSRO. In a few words, indicate the serious impositions it will impose on your practice and how your patient's medical care will be adversely affected. The following is an example of such a note:

"Dear Patient:

In less than two years a massive new government medical organization will be started in the United States—(Professional Standards Review Organizations). This will require physicians to spend nearly 15 percent of their practice time reviewing hospital charts and office records to determine if the government can alter payments for your medical services. Please help to repeal this law which will greatly decrease the time I will have to see you and my other patients. Write to Senators Herman Talmadge, Sam Nunn and Russell B. Long, Senate Office Building, Washington, D.C. 20510 and to Representatives Bill Stuckey, Phil Landrum and Wilbur D. Mills, House of Representatives Office Building, Washington, D.C. 20515.

Thank you,
Your Doctor"

Two months later, a note could go in as follows:

"Dear Patient:

I hope you have had time to become more informed about PSRO legislation which becomes active in 16 months. We now find that under this program your medical records will no longer be confidential and must be turned over to a Civil Service worker upon request. If a person's medical problems aren't private, what is? Please write to (name Senators and Representatives along with their addresses).

Thank you,
Your Doctor"

These are some points that have occurred to me and other members of our Society in this important matter. In actual truth, the ultimate influence on the federal government and its elected officials will be the voice of its constituents. The local medical society and its physicians who have personal contact with patients is the most potent motivating force available to force public opinion on the Senators and Representatives. The main thing is that we can't just talk about it; we've got to start doing it! Please make every effort to get your County Medical Society active in starting some of these programs. ■

Still Have Questions? Call a Colleague

If the material in this Special Issue of the *Journal* has raised questions in your mind or if your patients ask for further information, you may want to contact someone quickly for the answers you seek. Listed below are the members of MAG's Committee on PSRO, which has gone into the law and its ramifications in depth. In addition, several county societies have set up their own PSRO committees or designated knowledgeable members who should be contacted for information on this subject.

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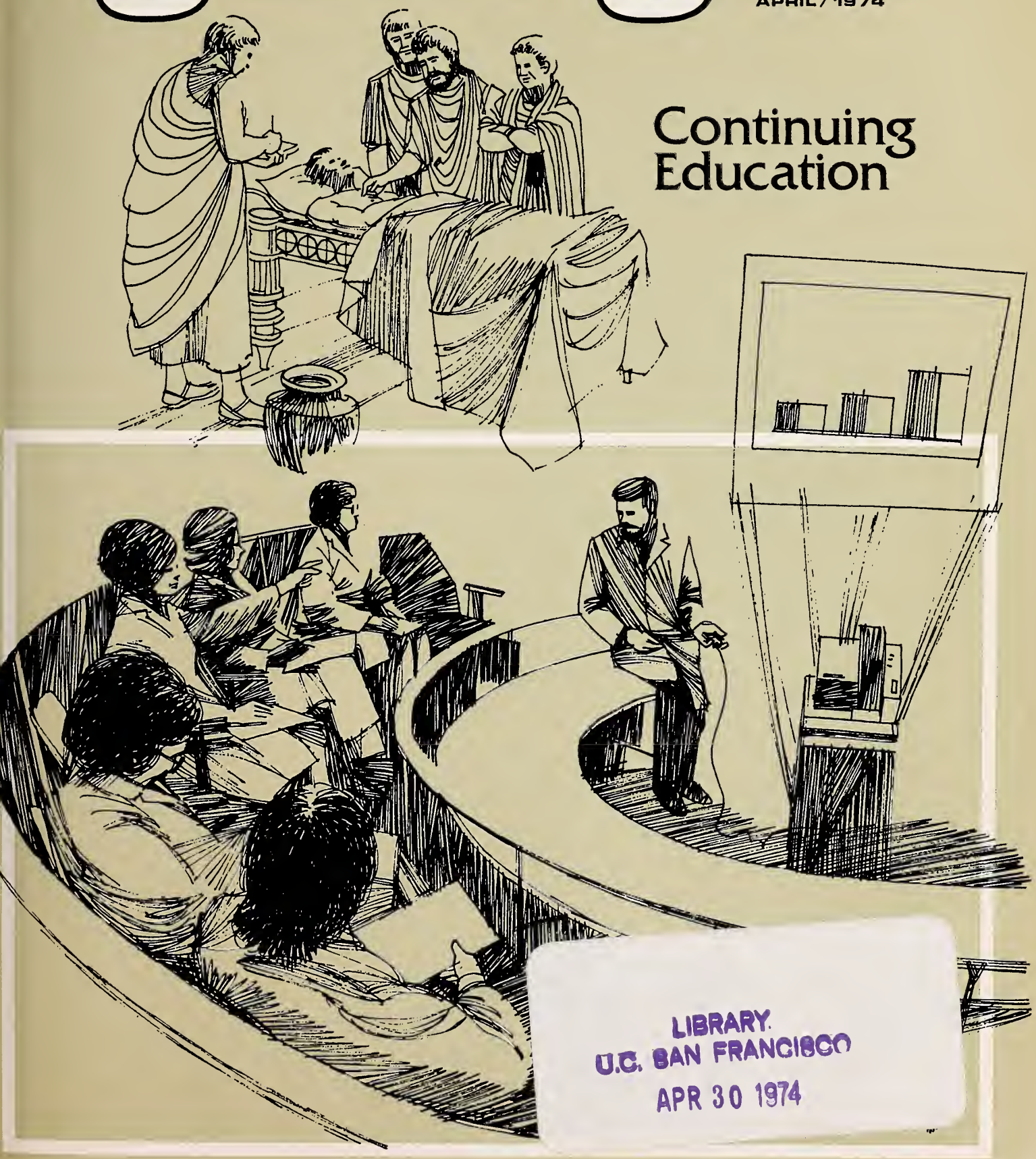
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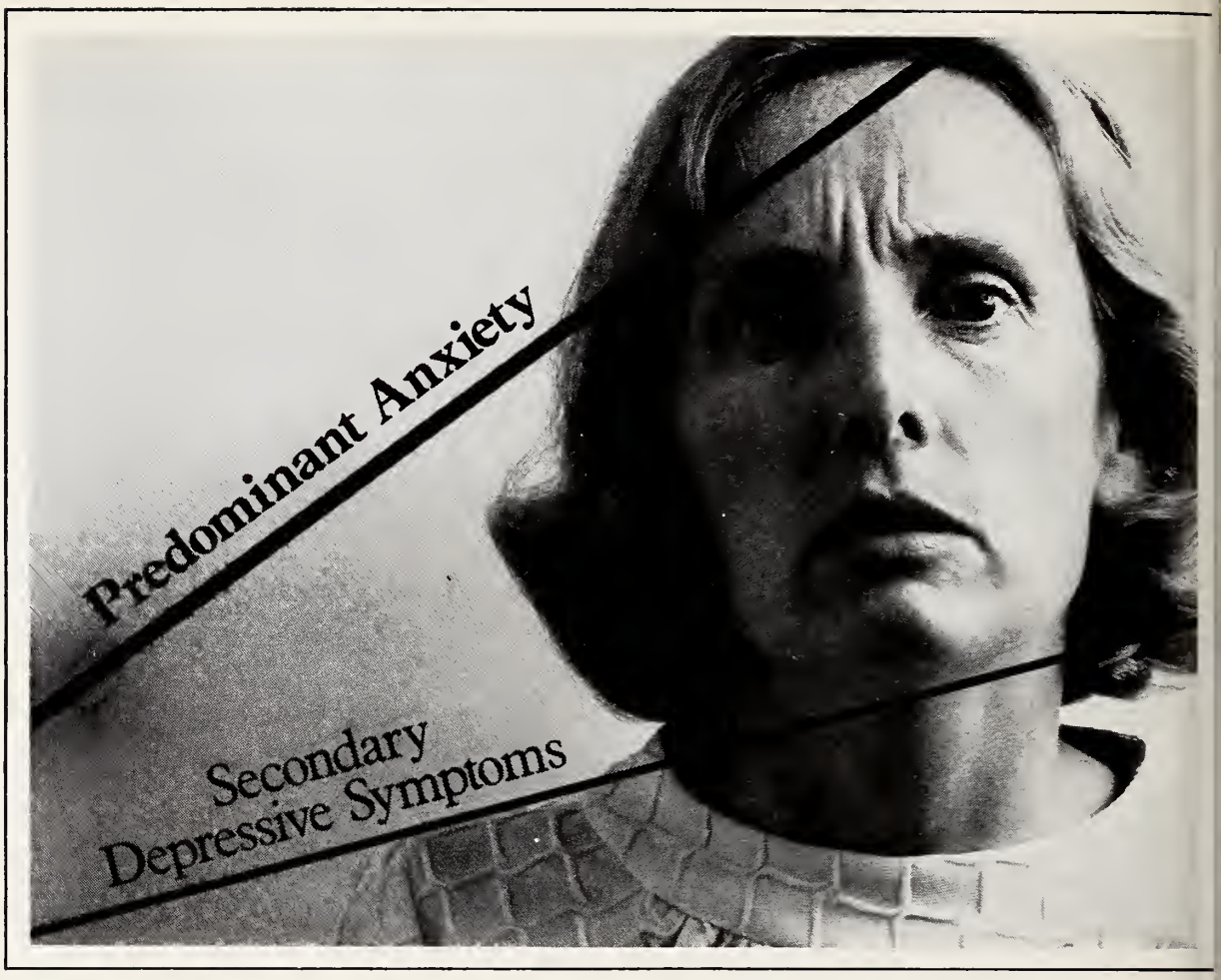
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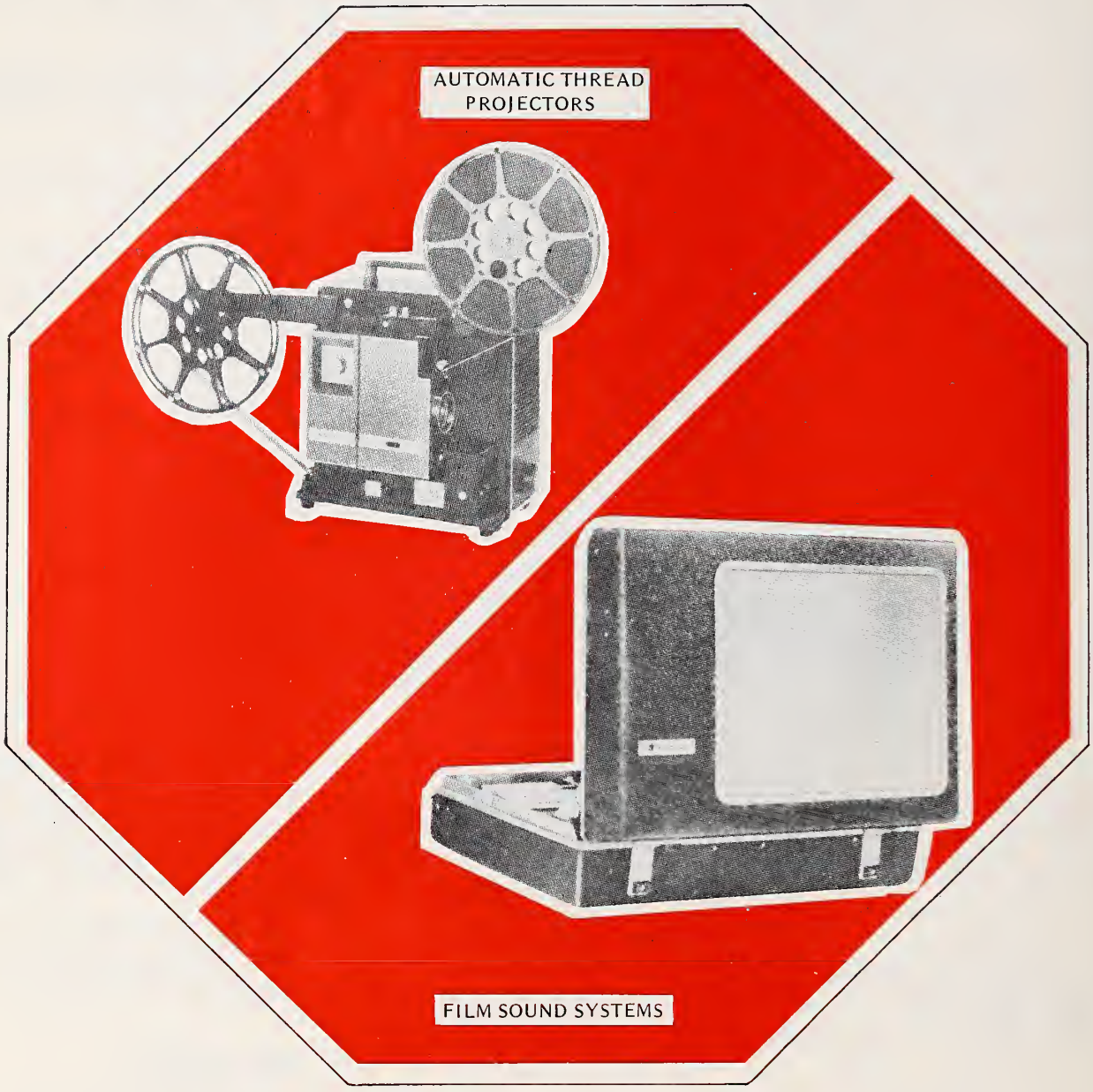
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THE COVER

The never ending process of keeping up through continuing medical education is the theme of April's *Journal*. Illustration by Jack Smith, Atlanta.

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Many areas are carefully considered when surveying institutions for possible accreditation.

Accreditation of Programs of Continuing Medical Education by the Medical Association of Georgia

LAMAR S. MCGINNIS, M.D., *Decatur**

In June of 1973, the Council on Medical Education of the AMA approved the Medical Association of Georgia's continuing medical education accreditation program. This has enabled the Sub-Committee on Accreditation of MAG to begin to carry out surveys of on-going programs of continuing medical education within our state. Organized medicine has faithfully exercised its responsibility to assure appropriate quality in education, beginning in the early 1900's with accreditation of medical schools, following in the 1920's with accreditation of programs of postgraduate education, and subsequently with accreditation of programs of continuing education for physicians beginning in the late 1960's.

The Medical Association of Georgia's accreditation program is focused primarily on these types of institutions:

1. Local community hospitals which have continuing medical education activities limited to the hospital staff and physicians of the local community.
2. Medical organizations which do not have national scope, e.g., county and other local societies, such as the Georgia Surgical Society and the Georgia Orthopedic Society, etc.
3. Local units of voluntary health organizations not under national administration for their continuing medical education, such as the Georgia division of the American Cancer Society, the Georgia Heart Association, etc.
4. Other organizations and institutions which sponsor or promote continuing education for physicians, essentially local in nature, and appropriate to the needs of the profession such as the Atlanta Graduate Medical Assembly, the Atlanta Society of Pathologists, etc.

Piedmont Hospital has been approved for accreditation for a three-year period. The Atlanta Graduate Medical Assembly has been surveyed for accreditation. The Atlanta Society of Pathologists, the Columbus Medical Center and the Medical Center of Central Georgia have all applied for surveys of their programs of continuing medical education for accreditation.

Areas of Consideration

In surveying institutions or organizations for accreditation, the following broad areas are especially considered:

1. That adequate qualified leadership and a strong institutional commitment in favor of continuing medical education is present.
2. That a written set of objectives to indicate what the continuing education program hopes to accomplish to improve physician competence and patient care is available.
3. That a realistic budget has been established.
4. That a competent teaching staff is available locally or on a consulting basis.
5. That a curriculum of suitable breadth and depth to meet the designated needs of the medical audience is planned.
6. That a diversity of educational methods will

* Chairman of the Sub-Committee on Accreditation of the Education Committee. Dr. McGinnis' practice is located in Suite 201, 365 Winn Way, Decatur, Ga. 30030.

be utilized, particularly participative educational methods.

7. That adequate facilities for continuing education with suitable audio-visual aids are available.

8. Most importantly, that some method of audit or quality of care evaluation is utilized to determine if the continuing education program for physicians has indeed accomplished its goals.

For a hospital to carry on an adequate program of continuing medical education, utilizing primarily its own staff as a resource, the Education Committee feels that at least a staff of 15 physicians is desirable. Smaller hospital staffs could carry on adequate programs of continuing medical education utilizing consultative services from medical schools or other consulting hospitals. A sporadic or episodic program of continuing education, not particularly based on the needs of the local medical community, as reflected through the institution-patient mix, could not be considered adequate for accreditation. Likewise, organizations other than hospital medical staffs, which present only an occasional program or conference, unrelated to the needs of their physician audience, would probably not be acceptable for accreditation.

Interest Increases

The usefulness of the accreditation mechanism as a means to improve the quality of continuing medical education appears to be gaining strength, although, in Georgia, it is a wholly voluntary system. For a variety of reasons, specialty societies, state medical societies, and state licensing organizations are becoming increasingly more interested in continuing medical education. The American Academy of Family Physicians continues its tradition of requiring continuing medical education for maintenance of membership in the Academy. Six state medical associations require certain amounts of continuing medical education, of recognized quality, for maintenance of membership. Three state licensing boards require certain amounts of continuing medical education for re-registration of the license to practice. With more than two-thirds of hospitalized patients treated at the community hospital level in this country, the Medical Association of Georgia is focusing the emphasis of continuing medical education at the community hospital level. It is felt that these programs must be closely related to the needs of the particular physicians in that hospital, as reflected through an audit of the care being carried out in that hospital. The accreditation mechanism is a means of applying a certain measure of quality, and certain standards, through which the whole program may be upgraded.

Hospitals or organizations interested in establishing programs of continuing medical education, or hospitals or organizations with established programs of continuing medical education, but who are interested in having their programs surveyed for accreditation, should contact the Medical Association of Georgia for further information in this regard.

The members of the Sub-Committee on Accreditation stand ready to assist any hospital or organization in establishing programs of continuing medical education that may be surveyed subsequently for accreditation. ■

Highlights of Executive Committee of Council

March 9, 1974

Appointments: PSRO Committee—Claude A. Boyd, M.D., Augusta; Interprofessional Council—James H. Manning, M.D., Marietta.

Life-Sign: Endorsed Medical Profile System's ID card with medical information on microfilm.

JMAG Advertising Policy: Reaffirmed policy statement on not accepting advertising for physician laboratories.

GRMP: Received report on release of impounded funds, approximately $3.5 million for Georgia through February 1975.

HMO: Voted to continue opposition to any state HMO legislation. Approved development of position paper on opposition to HMO.

Cancer Network: Approved submission of grant request for a Cancer Network Program with MAG serving as the grantee.

Teaching experiences at the place of practice—the community hospital—can provide benefits for everyone involved.

Education and the Community Hospital

MARK E. SILVERMAN, M.D. and J. WILLIS HURST, M.D., *Atlanta**

MEDICAL SCHOOLS HAVE NEVER produced a finished product. The practice of excellent medicine requires the physician to seek additional knowledge continually and to apply the knowledge to his everyday practice. Despite a general recognition that the best learning experience is gained when educational pursuits are directly linked to current patient problems in the office or hospital, many physicians have attempted to satisfy their educational desires by attending postgraduate courses. Unfortunately the majority of courses, although well intentioned and planned, have provided only a brief, intense exposure that tans the surface but does not seem to permeate through to become permanently incorporated into the daily practice of medicine.

Since the practice of medicine takes place in the office and in the hospital, it seems logical to develop an educational program at the place of practice rather than to transport the physician to an educational experience dislocated from his patients. This concept has led the American Medical Association and its affiliates to regard the community hospital as a possible major center for postgraduate education.

University medical schools have also realized the potential of the community hospital as an educational center and have begun to combine their educational talents with the resources and clinical opportunities in the community hospital. The Department of Medicine of Emory University School of Medicine has been in the forefront of establishing a community hospital-university relationship and currently has combined programs at Columbus Medical Center, Columbus, Georgia, and Georgia Baptist Hospital, Northside Hospital, and Piedmont Hospital in Atlanta. Through these programs the University has been able to work closely with the practicing physician in developing superior medical care. This cooperative venture has a number of distinct advantages to the community hospital and to the University.

The University benefits because:

1. The community hospital offers a large group of experienced, practicing physicians who can contribute to student and fellow education. As the students and fellows have rotated through the community hospital, they have acquired respect for the formidable task of practicing medicine and admiration for the physician and his experience gained from following patients for many years.

2. The community hospital provides a large patient population that can be utilized for teaching. This is of particular importance at this time when expansion of medical school classes has placed a strain upon University facilities, staff, and patients. The students have also learned that unusual diseases and difficult diagnostic problems are not unique to university centers.

3. The community hospital provides the student an exposure to the practice of medicine. In the past, medical students have had little or no opportunity to experience the practice of medicine prior to making the crucial decision of internship and residency. This community hospital experience, although brief, provides a partial solution to this problem.

4. The community hospital provides an opportunity for the University to extend its postgraduate programs and ideas directly into the place where the physician is practicing. This may take the form of monthly faculty speakers, seminars, consultations, educational techniques such as the problem oriented system, videotapes originating from the University center and the real possibility of bringing new uni-

* Dr. Silverman is an associate professor of medicine for Emory University School of Medicine and an Emory-Piedmont professor of medicine, 1968 Peachtree Road, N.W., Atlanta, Ga. 30303. Dr. Hurst serves as professor and chairman of the Department of Medicine, Emory University School of Medicine, 69 Butler St., S.E., Atlanta, Ga. 30303.

versity ideas, techniques and drugs quickly into the everyday practice of medicine.

5. The community hospital setting is a relatively unique opportunity for students and fellows to have very close supervision by faculty or by an experienced practicing physician.

The community hospital benefits because:

1. The University provides students, fellows, and faculty that stimulate the community physician to advance his own education. The presence of students cannot be overestimated as an important contribution to a learning environment.

2. The University faculty member and fellow organize, develop and often direct sophisticated diagnostic laboratories and intensive care areas. This might include coronary care, intensive care, dialysis, or respiratory units, cardiac catheterization laboratories and noninvasive cardiac testing such as treadmill exercise, phonocardiography and echocardiography. This adds immeasurably to the capabilities of the hospital and directly improves patient care.

3. The faculty member and fellow offer immediately available consultation and continuous specialized care for acutely ill patients. This allows the practicing physician the opportunity to extend his care to many patients rather than cancel his appointments to remain with one critically ill patient.

4. The faculty member often organizes the conferences and other teaching activities, brings other faculty members to the hospital for conferences or panels, stimulates the practicing physician to prepare conferences and improves the library and other educational facilities in the community hospital.

5. The education of physicians and students usually spills over into the area of nursing education, paramedical education and patient education. Coronary care and intensive care unit nurses in particular have benefited from the interest and attention. This has relieved the practicing physician of the responsibility of retraining personnel and has brought an exciting improvement in patient care.

6. In many community hospitals there is no physician immediately available for emergencies such as cardiac arrest. The presence of a full time, knowledgeable physician provides someone who can respond to the emergency until the personal physician arrives.

7. Finally, the university association brings the community hospital recognition as a teaching, university related hospital, enhancing the prestige of the hospital.

The experience and ideas gained from these programs and others is also applicable to community hospitals without a university affiliation. Although it seems desirable to have a full time director of medical education, the most essential requirements are one or more physicians who are interested in education and a hospital administration that believes that good patient care is contingent upon an active educational program.

The best educational program involves physicians, nurses, and patients. The needs of each of these groups is often best unified by an education committee that serves as a forum for representatives of the various activities throughout the hospital. Ongoing or contemplated activities can be presented for discussion, suggestions and intramural cooperation.[1]

Physician Education

A weekly conference or a journal club is usually the easiest physician activity to initiate. The educational experience, however, is usually very passive unless the conference is directly related to a patient currently being seen in the office or hospital. The patient should not be utilized as a springboard to a review of the subject or as a listing of the differential diagnoses. Although this may relate tangentially to the patient, the relationship is not by consanguinity but through long distance communication. The lecturer usually gains in knowledge but the audience and the patient may not be improved. The conference is most useful when there is a group discussion of the patient and an analysis of how the patient's problems are being solved. The problem oriented medical system which promotes defined information collecting, thoroughness, accuracy, reliability, efficiency, patient education, communication, audit of performance and feedback correction of deficiencies can be utilized to advantage in this type of conference.[2] Panel discussions, review of self assessment tests, and morbidity and mortality reviews offer a high level of education since there is active participation by many people and audience interaction.

Quality care assessment, sometimes considered an onerous task, can become an exciting effective approach to education if used constructively. Problems should be selected from the most common illnesses seen at the hospital. Criteria for excellent medical care and diagnosis are developed at one conference. These criteria are then applied to actual performance in that hospital and the results presented. An educational program is developed from the inadequacies noted in the survey. For example, if a survey of cerebrovascular disease revealed that few physicians listened for bruits in the neck, then a conference is designed to stress the importance of carotid artery stenosis. The problem should then be reaudited later to see if the discussion has had the desired effect.

This approach can also be used routinely in the office, using office personnel to audit the charts.[3]

A library should be readily available that contains current journals and books selected for the type of practice in the individual hospital. Recently the American College of Physicians and the *New England Journal of Medicine* have published a core curriculum that can be used as a guide for journal and book selection.[4-6] There should be access to a regional library for unavailable references. The library should also contain audiovisual material such as audio-cassettes, slide-sound programs, and videotapes for reviewing or listening in the library or at home.

Finally, consultations should be regarded as a learning opportunity and every effort made to review the patient with the consultant. The consultant should provide references for the referring doctor.

Nursing Education

Until the advent of coronary care units physicians often neglected the postgraduate education of the nurses. The benefits of teaching CCU/ICU nurses to become highly skilled are now obvious and should promote a similar approach to the education of floor nurses. This should lead to better floor care, less personnel loss, and a return of many qualified nurses who currently seek the attention and excitement of the specialty units. The education of the nurse can be done simply enough by returning to the former tradition of rounding with the nurse and discussing the patient with her. Fifteen minute patient oriented conferences once or twice a week are often a great source of enjoyment and learning to the nurses. These mini-discussions can be recorded on audio-cassettes and replayed for later shifts or kept in the library. Nurses should be taught physical diagnosis and asked to record and analyze their findings carefully. By reading the nurse's note and making corrections or additions to her comments, the physician can impart an enormous educational influence on the nurse when she returns to read the note. Since she is aware that the physician is reading and appreciating her observations, she will become more involved with the patient, learn to make skilled observations, and also be stimulated to read about the problem.[2]

A weekly nurses' "grand rounds" should be routinely held on subjects selected and prepared by the nurses. Physicians may need to participate in the early development of this conference until the nurses feel confident to organize and direct the program by themselves. Nurses, like physicians, learn more if they have to prepare the material for presentation.

Finally, nurses must be encouraged by the physician and the nursing director to develop regular reading habits at home of books and journals on tients to which they are assigned.

Patient Education

Patient education should be an important goal of every hospital and office. This should have the following objectives:

1. Change patient behaviour toward better self care.
2. Facilitate maximum patient recovery or rehabilitation in the shortest possible time.
3. Decrease the patient's need for specific medical services.
4. Provide follow-up education and resources for the patient after hospitalization.
5. Utilize physicians' time more effectively.
6. Promote good health by increasing the awareness of health problems through active prevention programs.

These objectives, although visionary in scope, can be attempted by any hospital and office at very little expense by utilizing already available resources. Excellent pamphlets and film strips are available at little or no cost from the local chapters of national service organizations such as the American Heart Association, American Cancer Society, Diabetes Association, Tuberculosis and Respiratory Disease Center, etc. This material has been specifically prepared for patients and can be displayed or made available in the office waiting room, hospital lobby, and floor lounge or solarium. Many companies have recently begun to produce audiovisual aids for patients. These include coordinated slide-sound tapes, cassette movies and videotapes. The projector can be placed in a waiting room, lobby, office or taken to a patient's room in the hospital. Some hospitals are equipped to broadcast videotapes over the television in each patient room. Audiovisual programs are easily operated and have the advantage of not tiring when repeating the information.

One of the most talented, yet overlooked aids to patient education is the nurse. Nurses are particularly expert in educating patients about drugs, diet, and home care. An enormous improvement in the patient's ability to take medications correctly (and to recognize medication mistakes) occurs simply by having the nurse give the patient the name and purpose of each medicine that is ordered. Nurses are eager to participate in patient education and will devote considerable effort if they are enlisted to help.

The hospital abounds with paramedical personnel that can assist in teaching. Examples include the dietician, physical therapist, woman's auxiliary, and the hospital librarian. In the office a secretary or medical technician can instruct or guide the patient.

Another approach to patient education would be

to centralize community and professional educational resources in an area directly accessible to patients. This health education center would be part of the hospital and serve patients, physicians, and nurses. A librarian or health education coordinator will provide information and guidance toward the understanding of disease and preventive medicine. This could include pamphlets, books, audiovisual material or specialized counseling. Lectures or group sessions with physicians, nurses, and dieticians can be planned. The woman's auxiliary can take material to patients too ill to leave their rooms. Videotape programs can be broadcast through a central antenna to each room, to the lobby and even to physicians' offices. Physicians can be encouraged to develop their own educational materials such as slide-sound programs, videotapes or handout material to store in the library for their patients. In some cases the physician might "prescribe" the type of education. In other cases the physician might send the patient to the health education coordinator for evaluation of the type of education that is required. Patient education should become an exciting contribution to health care in the coming years.

The Task Force on Continuing Education of the Medical Association of Georgia with the guidance of the American Medical Association has recently developed a survey form which can be used by hospitals interested in developing educational programs and evaluating current hospital resources. Some of the important questions that are asked are listed below.

1. Objectives
   - What are the objectives of the education committee?
   - How were the objectives developed?
   - How do the objectives relate to the educational program?
2. Educational programs
   - Does the education committee survey the needs of the physicians, nurses, and patients?
   - Does the program attempt to meet these needs?
   - Is there a demonstrable effect of these programs on hospital or community practice and patient care?
   - How is the quality of the programs evaluated?
   - Is there an effort to review and revise the program?
   - What are the reactions of the participants and faculty to the program?
   - Do the programs meet general needs as well as the needs of specialty groups?
   - Who actually plans the programs?
   - What are the types of programs?
3. Education committee
   - Who is on the education committee and what are their qualifications?
   - How much time do they spend?
   - What other committees are they on?
   - What is the relationship of the education committee to the other hospital committees and Board of Trustees?
   - What is the budget of the committee and does it support the quality of education desired?
4. Resources
   - What is the size and suitability of classrooms or auditorium?
   - What kinds of teaching aids and audiovisual equipment are available?
   - Are patients used for teaching?
   - What library resource is available and what is the size, budget, personnel and utilization of the library?
5. Teachers and participants
   - How many of the hospital staff attend conferences or other activities?
   - How many of the hospital staff actively participate in teaching?
   - How many physicians are on the staff of the institution and how many hold faculty appointments at a medical school?
   - Are guest teachers part of the program, how are they utilized, and are they paid?

"Knowledge comes," said Tennyson, "but wisdom lingers." It is obvious that the community hospital educational programs can bring knowledge to the physician, nurse, and patient. Whether this knowledge will linger cannot be answered at this time. The possibility of directly infusing education into the daily practice of medicine is challenging and could be a major trend of postgraduate education in the future. ■

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6. Stearns, N. and Ratcliff, W. W.: An integrated health-science core library for physicians, nurses and allied health practitioners in community hospitals; *New Engl. J. Med.* 283:1489-1498, 1970.

The College increasingly is involved in developing a wide variety of programs in response to specific needs of outside organizations.

Continuing Medical Education and the Medical College of Georgia

GLEN E. GARRISON, M.D., *Augusta**

A PHYSICIAN TYPICALLY COMPLETES his residency training and begins his practice when he is approximately 32 years of age and then has a professional life expectancy of 30-40 years ahead of him. With the half-life of a physician's education at the end of his residency currently estimated to be approximately seven years, continuing education is essential throughout his entire professional career in order for him to renew his knowledge and keep abreast of new developments in medical care.

The three main ways that physicians continue to learn throughout their careers are 1) regularly reading journals and books, 2) informal discussions with their medical colleagues about problems that they encounter in their practices followed by selective reading and study on those topics, and 3) attendance at continuing education programs presented by hospital staffs, professional societies, and medical schools.

The amount of continuing education that is obtained through the first two of these methods is completely undocumented because the use of these methods is highly personal and is not readily visible to others. In contrast, attendance at continuing education programs is much easier to document, but overall records are not available on physicians' attendance at continuing education programs because these courses are presented by many different institutions and organizations. However, informal observation of the attendance at continuing education programs presented by numerous different organizations strongly suggests that the physicians who attend programs presented by one organization usually also attend programs presented by other organizations. In addition, it is generally felt and in one instance has been quantitatively documented that a small percentage of the total number of physicians in a state attend the majority of the enrollee-hours recorded in continuing education courses presented by state-supported medical schools having sizeable, diversified, and decentralized continuing education programs.[1]

At the other end of the spectrum it is widely recognized that some physicians receive little, if any, identifiable continuing education; and such physicians practice in both urban and rural locations. Both the knowledgeable public and the medical profession have become concerned about this problem, and the medical profession is now beginning to provide leadership to eliminate it.

The American Academy of Family Physicians was the first professional society of physicians to require its members to attend approved continuing education programs as a prerequisite for maintaining their membership in the society. Recently, six state medical societies in the United States have adopted similar requirements. These states are Oregon, Arizona, Pennsylvania, Massachusetts, New Jersey, and Florida. Furthermore, three states—Maryland, Kansas, and New Mexico—have passed laws requiring each physician to attend continuing education programs as a prerequisite to reregistering his state license to practice medicine. Similar plans are now being considered in additional states.

Courses Presented

The School of Medicine of the Medical College of Georgia has provided some continuing education for physicians for many years, but recently the magnitude of the effort has increased and diversified.

The current continuing education activities of our School of Medicine functionally can be divided into

* From the Program in Continuing Medical Education and the Division of Continuing Education, Medical College of Georgia, Augusta, Georgia 30902.

two types. The first type contains programs that originate primarily from within the Medical College of Georgia. These programs are announced by brochures and have advanced registration. Some of these courses are designed to attract a large regional or national audience, and others are developed to provide individualized instruction to small numbers of physicians practicing in Georgia. Most of the larger courses last either two or three days, but some are considerably longer. Table 1 contains a summary of the programs in this category during the academic year 1972-1973.

The second type of continuing education contains those programs that are developed in response to requests from organizations outside the Medical College of Georgia. The requesting organizations are usually the medical staff of hospitals or medical societies in the various counties or districts in Georgia. Some of these programs are announced by brochures and have advanced registration. The brochures are occasionally mailed to a wide geographic area, including national distribution for some programs. However, most of these programs are developed specifically for small local groups and often concentrate on specific problems that have been identified by the physicians who requested the programs. Table 2 contains a summary of programs in this second category during the preceding academic year.

In summary, the School of Medicine of the Medical College of Georgia presented 266 continuing education programs in 26 different cities and towns in Georgia and in a still larger number of different institutions within these communities during the academic year 1972-1973. These programs were attended by 2,373 physicians, 671 registered nurses, 704 other nursing personnel, 71 allied health personnel, 6 dentists, and 774 other people for a total enrollment of 4,599. These enrollees in the courses presented by the School of Medicine comprised 74 per cent of the total enrollment in continuing education programs of the entire Medical College of Georgia. The total enrollment in all 305 continuing education courses presented by the Medical College of Georgia during the year was 6,237. These individuals came from 37 different states with 72 per cent of the total enrollees being from Georgia and residing in 132 of its 159 counties. Table 3 contains an analysis of the types of practices of the physicians who attended these courses.

Faculty Participation

Last year 2,123 hours of instruction were given in the 305 courses presented by the Medical College of Georgia. This teaching was done by 285 different individuals with 211 of them being on the faculty or other professional staffs at the Medical College of Georgia. A total of 74 guest faculty members participated in providing the instruction. Among the total faculty teaching in these continuing education programs were 94 full professors, 51 associate professors, 66 assistant professors, and 20 instructors. The School of Medicine presented 87 per cent of the 305 institutional courses, and the bulk of the above

TABLE 1

PROGRAMS ORIGINATING PRIMARILY FROM WITHIN THE MEDICAL COLLEGE OF GEORGIA
(Presented between July 1, 1972 and June 30, 1973)

Descriptive Topics	Number of Programs	Location of Programs
A. Programs for the Southeastern or Entire United States		
Internal Medicince	1	Buccaneer Motor Lodge, Jekyll Island
Gastroenterology	1	Medical College of Georgia, Augusta
Family Practice	1	Medical College of Georgia, Augusta
Obstetrics and Gynecology	1	Savannah Inn & Country Club, Savannah
Endocrinology	2	Medical College of Georgia, Augusta
Electron Microscopy	1	Medical College of Georgia, Augusta
Cancer	1	Medical College of Georgia, Augusta
Sickle Cell Anemia	1	Medical College of Georgia, Augusta
Pulmonary Diseases	4	Medical College of Georgia, Augusta
Psychiatry	1	Medical College of Georgia, Augusta
B. Programs Specifically for Audiences in Georgia		
Neonatal Care	2	University Hospital, Augusta
Neonatal Care	1	Medical Center of Central Georgia, Macon
Neonatal Care	1	Hamilton Memorial Hospital, Dalton
Neonatal Care	1	Memorial Medical Center, Savannah
Family Practice	1	Medical College of Georgia, Augusta
Internal Medicine	10	Medical College of Georgia, Augusta
Totals	30	7 Different Locations in Georgia

described instruction was given in these medical courses.

Unique Component

Undoubtedly, the most unique aspect of the continuing education activities of our School of Medicine is those programs that are developed to help solve specific problems identified by practicing physicians relative to medical care in their own community. A description of some of these problems will illustrate the kinds of educational services that our School of Medicine has provided. Since approximately 1967 our school has been asked to provide consultation and instruction in dozens of different instances to numerous hospitals in Georgia relative to coronary care units. In response to these requests, we have reviewed the quantitative impact of a coronary care unit on health, the volume of acute myocardial infarctions needed to operate a unit from the financial viewpoint and from the perspective of having enough such patients to enable the medical and nursing staffs to maintain professional competency in this type of care, and the details of setting up and operating such a unit.

In other instances, we have been asked to review specific operational problems in local hospitals and develop educational programs to help the medical and nursing staffs and also the hospital administration identify the various alternatives that could be used to improve those situations. Specific examples in which we have been asked for assistance include organizational and technical problems in operating rooms, elimination of electrical hazards to patients, and identification of appropriate new equipment for medical care. Occasionally, very sensitive professional and/or political issues within the local hospital or community were factors in stimulating the local medical group to seek our consultation to identify appropriate alternative courses of action. In still another instance, we were asked by the medical staff to develop educational programs relative to a serious unresolved conflict which had become sharply delineated between the medical staff and the governing board of that hospital. In addition, we have been asked to provide instruction on the professional and legal aspects of utilizing the newly trained physician assistants and on the organizational aspects of community-based programs for birth control and also for emergency medical care.

This list is not exhaustive, but it is indicative of the types of requests that our Program in Continuing Medical Education has received from physicians throughout Georgia. The solutions to the problems usually have involved both physicians and nurses and occasionally other groups such as county commissioners and civic clubs in the local community.

TABLE 2

PROGRAMS DEVELOPED IN RESPONSE TO REQUESTS FROM ORGANIZATIONS OUTSIDE THE MEDICAL COLLEGE OF GEORGIA
(Presented between July 1, 1972, and June 30, 1973)

Descriptive Topics	Number of Programs	Location of Programs
A. Programs for National Audiences		
Major Issues in Medical Care	1	Atlanta
Pediatric Ophthalmology	1	Sea Island
B. Programs for Regional Audiences in Georgia		
Multidisciplinary	5	Dublin
Multidisciplinary	4	Dalton
Multidisciplinary	1	Rome
Multidisciplinary	1	Cordele
C. Programs for Local Audiences in Georgia		
Multidisciplinary	23	Adel
Multidisciplinary	5	Albany
Multidisciplinary	18	Americus
Multidisciplinary	2	Augusta
Multidisciplinary	12	Cedartown
Pediatric Cardiology	2	Columbus
Multidisciplinary	12	Dublin
Multidisciplinary	20	Elberton
Multidisciplinary	12	Hawkinsville
Multidisciplinary	24	Jesup
Multidisciplinary	3	Louisville
Atherosclerosis	1	Oglethorpe
Multidisciplinary	7	Macon
Multidisciplinary	13	Sandersville
Multidisciplinary	6	Savannah
Organization of Medical Services	1	Thomasville
Multidisciplinary	24	Tifton
Multidisciplinary	2	Valdosta
Multidisciplinary	12	Warner Robins
Multidisciplinary	24	Washington
Totals	**236**	**25 Different Locations in Georgia**

In these situations, the role of our Program in Continuing Medical Education is to arrange the appropriate consultative and educational services needed to help the local medical groups and hospitals formulate the various potential approaches to solving the problems that they have identified.

When our Program receives such a request, the individuals who are appropriate to help with the problem are often readily apparent to me. In other instances I discuss the situation in greater detail with the requesting physician by telephone in order to define the problem more clearly. In identifying the potential approaches for helping solve a specific problem, I often seek advice from one or more other members of our faculty and occasionally from other physicians in Georgia. Frequently, the individual whose advice is initially sought is then asked to provide the assistance needed in the local hospital. The majority of these educational services are pro-

vided by the faculty of the Medical College of Georgia, but individuals outside our institution are selected in those instances in which their knowledge and experience is felt to be especially pertinent to the particular need. After these consultative and educational services are provided in the local community, the pertinent decisions are then made by the local physicians in cooperation with others in their hospital and community. We at the Medical College of Georgia are, of course, interested in knowing about the decisions that are made and about the subsequent results because this information helps us render more effective consultative and educational services in the future. This process of making local decisions on medical problems within the community is extremely important, and I am most delighted to have the opportunity to assist in facilitating it.

In those communities in which our institution is initially asked to provide consultative services on a particular problem, we often are subsequently asked to develop a series of educational programs based on less intense local problems and also on other subjects of particular interest at the time. Separate programs for physicians and nurses are often developed in these educational series in order to give selective emphasis to the material that is of special interest to each of the two professional groups.

Administrative Organization

With the recent growth in continuing education activities in our state and also throughout the entire nation, we are now receiving numerous inquiries about the organizational arrangement of continuing education activities at the Medical College of Georgia. First, it should be appreciated that "continuing education" of professional groups and "educational public service" of various large components of the general public—although markedly different—share the common denominator of not being designed to give formal credit directly toward an academic degree. The overall University System of Georgia has recently merged "continuing education" and "educational public service" into this single administrative definition. Consequently, the continuing education and educational public service activities of all five schools at the Medical College of Georgia are administratively presented through the institution-wide Division of Continuing Education. The Program in Continuing Medical Education is the administrative unit for developing and presenting all continuing education activities of the School of Medicine.

Physicians and others attending the various programs presented by our School of Medicine may find the following information helpful. The Division of Continuing Education handles the registrations for all courses. Mrs. Freida C. Royal, conference coordinator, is in charge of the various administrative arrangements relative to most of the larger programs and is assisted by Mrs. Patsy A. Throckmorton, who handles advance registrations for these courses. Mr. Connie M. Connell, coordinator for extension services, works extensively in facilitating communication between our institution and practicing physicians in Georgia. He also supervises the schedules and the maintenance of necessary records for the individualized educational programs presented to the medical and nursing staffs in their own communities. Mr. Samuel E. Moyer, Sr., is our business manager, and Mrs. Joan B. Morgan is our administrative secretary. I have the overall administrative responsibility for our Division of Continuing Education and for our Program in Continuing Medical Education. All of us are pleased to assist in any way that we can in implementing educational activities that are desired.

Records of Attendance

An individual who attends continuing education

TABLE 3

TYPES OF PRACTICES OF PHYSICIANS ATTENDING PROGRAMS DURING THE 1972-1973 ACADEMIC YEAR

Types of Practice	Number of Physicians
Allergy	1
Anesthesiology	23
Cardiovascular Disease (Adult)	17
Dermatology	2
Family Practice	206
Gastroenterology	6
General Practice	714
General Preventive Medicine	1
General Surgery	216
Internal Medicine	254
Neurological Surgery	3
Neurology	1
Obstetrics and Gynecology	112
Occupational Medicine	1
Ophthalmology	110
Orthopedic Surgery	18
Otolaryngology	4
Pathology	43
Pediatrics	115
Physical Medicine and Rehabilitation	2
Psychiatry	34
Public Health	12
Pulmonary Diseases	16
Radiology	64
Thoracic Surgery	10
Urology	20
Other	36
Unspecified	339
	2,380*

* Seven of these physicians attended programs other than those presented by the School of Medicine.

courses presented by the Medical College of Georgia may request a written record of his attendance from our Division of Continuing Education. Such records are particularly important in helping a person document his continuing education to professional societies and to licensure boards.

The Southern Association of Colleges and Schools and the University System of Georgia now administratively use the Continuing Education Unit (C.E.U.) as the standard of measurement for continuing education programs. One C.E.U. is defined as "10 contact hours of participation in an organized continuing education experience under responsible sponsorship, capable direction, and qualified instruction." The continuing education programs developed and presented by the Medical College of Georgia for the various specific professional groups are awarded Continuing Education Units, and a permanent record of attendance at those courses is being maintained.

Georgia Regional Medical Program

The Visiting Consultant Program of the Georgia Regional Medical Program should receive special recognition because of its extremely important role in providing financial support for consultative and educational services to community hospitals in Georgia. The use of these funds is often necessary in facilitating the provision of these important services, especially in those instances in which the topic being covered is a new concept to most physicians and nurses in a local community, or is professionally or politically controversial, or is highly specialized. In addition, these funds are catalytic in introducing well-planned multi-disciplinary education into community hospitals in which such programs have not previously been held.

Future Projections

The topics covered in courses for physicians shift appreciably from year to year in response to changes in perceived needs. During the current year we are receiving requests for increased instruction on medical audit and its relation to quality assurance and payments for services provided to patients. Increased instruction is also being provided relative to community planning for emergency medical services, improved organizational approaches to implementing therapy for hypertension, and the management of chronic diseases in general. These current changes in requests from practicing physicians reflect the recent evolution in national priorities in medical care and are significantly influenced by recent federal legislation.

As medical audits become more widely used for the evaluation of medical care in hospitals throughout Georgia, some overt deficiencies in current practices will likely become apparent to the medical staffs of the various hospitals. The solution to these problems will often require the development of new educational programs.

Summary

The School of Medicine of the Medical College of Georgia is pleased to provide a wide spectrum of educational services to physicians and other health professional groups with primary emphasis on helping improve medical services throughout Georgia. ■

REFERENCE

1. Lewis, C. E. and Hassanein, R. S.: Continuing medical education—An epidemiological evaluation; *New Eng. J. Med.* 282:254-259, 1970.

CAMP FOR DIABETIC YOUTH OPENS REGISTRATION

The Georgia Diabetes Association has begun detailing plans for the 1974 session of the GDA Youth Camp which will be held July 30 through August 10, starting during the week and ending on Saturday because of the weekend gasoline problem.

This year's camp session will be held at Camp Waco, a YMCA-owned facility out of Bremen approximately 45 miles west of Atlanta. Recreational activities will include swimming, boating, archery, various net and ball games—all under the competent supervision of experienced personnel utilized from the Easter Seal Society Camp preceding ours.

Diabetic children ages 9 through 15 are eligible to attend; however a limited enrollment will be accepted so early registration is encouraged. Camperships, partial or full, will be available on an individual basis according to need.

The dining hall, cooks, and kitchen facilities will be excellent, supervised by qualified dietitians at all times. A physician will be in residence at all times, as well as nurses to staff the separate infirmary building 24 hours a day. Housing will be in small cabins—one counselor with six campers.

Additional information and applications may be secured by writing to the Camp Secretary, GDA Youth Camp, 762 Cypress St., NE, Atlanta, Georgia 30308.

Report on the 70th Annual Congress on Medical Education

RICHARD E. THOMPSON, M.D., *Columbus**

ONE HALF-DAY SESSION of the Annual Congress on Medical Education was concerned with the topic, "Teaching with Private Patients—The Problems." The basic premises were (a) that bedside teaching must continue, and (b) that it seems all patients may soon have third party coverage (such as from some form of national health insurance). This makes it very necessary to consider effective use of private patients in teaching.

This was viewed from the standpoint of the practitioner, the house officer, the hospital administrator and the full-time teacher. The central point made was not to let the patient become a pawn. Good education is related to good, high quality medical care.

From the standpoint of the resident-practitioner relationship, the resident may have more knowledge of the disease, but the practitioner has more knowledge of the patient, so they do have things to contribute to each other. The learning relationship should be two-way. The role of the hospital administrator is simple; he is to provide everything the patient, house officer, patient care physician and teaching physician need and at the same time hold down hospital costs. (No solution was suggested.)

The point was made that a full-time teacher is not a person in a white coat with his office in the hospital, as much as it is a state of mind. When the teacher has the same concern for *student* needs as for research projects, patient care responsibilities or administrative duties then he will be an effective "full-time teacher."

One of the speakers considered it a dangerous line of thinking that patient revenues fund the house staff, therefore we are tempted to speak in terms of the house staff "responsibility to the hospital." This would lead to service-oriented internship and residencies, which is an undesirable situation. Rather, the director of medical education must look at educational needs of the house staff.

Problems and Solutions

Additional problems mentioned with using private patients for teaching include:

1. Professional liability
2. Informed consent
3. Cost analysis (patient care vs. education)
4. PSROs

Some answers suggested were:

1. Telling the patient in advance that he will be cared for by his own physician plus a house officer. Educate the patient to the fact that he is not just a donor of teaching material, but a recipient of better care because of this "partnership."

2. Continuing education for the physician will help narrow the gap between his knowledge and the resident's. (It was interesting to me to think of how many of the questions of using private patients for teaching can be approached by the full-time teacher having a commitment to continuing education equal to that he feels for house staff and student education.)

3. It is not good to have the resident cancelling the private physician's orders and vice versa. The house officer should write orders mainly, but with good communication with the private physician.

4. "Arrogance," felt sometimes by the house officer and private physician, may really be a lack of communication. Perhaps the most important thing is to increase the communication between the house officer and private physician.

5. It is necessary that the house staff be kept from having a relationship *only* with their full-time chief. This probably is up to the full-time chief. He must be sure that the resident relates to the private physicians.

Federation of State Medical Boards

William D. Mayer, M.D., dean at the University of Missouri-Columbia, gave an excellent summary

* Dr. Thompson, a member of the MAG Education Committee, attended this AMA sponsored Congress which was held February 1-3, 1974, in Chicago, Illinois. Dr. Thompson's address is P.O. Box 951, Columbus, Ga. 31901.

of some of the changes in medical education with which state boards will have to deal. These changes include increased variation and shortening of the curriculum; increasing feeling that medical school is a prep school and graduate medical education is now necessary before practice; and the discrepancy between the educators' views and the licensing boards' views. Many boards still license either immediately following medical school or following internship.

Other changes include the advent of the family practice residency; new programs in continuing medical education; and identifying the need for self-assessment exams and audit-related continuing education programs as part of re-certification or renewing one's license to practice. It was emphasized that the most important thing for medical students now is to "learn to learn," since much information gained in medical school will be obsolete after the first four or five years in practice. This raised the thought again of the increasing importance of continuing medical education. ■

Highlights of Council

March 9-10, 1974

Appointments: To the Georgia Medical Care Foundation's Board of Directors:

District	*Director*
1	C. E. Bohler, M.D. (1975)
2	Frank R. Miller, (1976)
3	John G. Bates, M.D. (1977)
4	L. C. Buchanan, M.D. (1975)
5	John R. McCain, M.D. (1976)
6	Jack S. Menendez, M.D. (1977)
7	Donald R. Rooney, M.D. (1975)
8	L. C. Durrence, Jr., M.D. (1976)
9	Louis G. Cacchioli, M.D. (1977)
10	L. H. Thomas, Jr., M.D. (1977)

District	*Alternate Director*
1	J. K. Quattlebaum, Jr., M.D. (1975)
2	L. T. Crimmins, M.D. (1976)
3	Harold G. Jarrell, M.D. (1977)
4	George R. Jones, M.D. (1975)
5	R. J. Van de Wetering, M.D. (1976)
6	J. M. Almand, Jr., M.D. (1977)
7	Benjamin S. Anderson, M.D. (1975)
8	Michael A. Glucksman, M.D. (1976)
9	T. N. Lumsden, M.D. (1977)
10	M. C. Adair, M.D. (1977)

MAG Officers: Referred to Constitution and Bylaws Committee for recommendations questions of speaker, vice-speaker, chairman and vice-chairman of Council being members of House and Council, respectively.

GMCF: Approved changes in bylaws establishing geographical representation on Board of Directors without qualification of membership in Council. Approved Foundation's CHEC Program (concurrent hospital review) to supercede such programs of insurance carriers and intermediaries. Expressed commendation for F. William Dowda, M.D. as president of GMCF. The GMCF new WATS line number is 1-800-282-2614.

PSRO Repeal: Received report on progress of repeal PSRO effort—all-member mailing, press conference, office tent card, plans for Rally, and notification of other state medical associations.

PSRO Areas: Latest word from Washington, D.C. seems to favor a single statewide PSRO area for Georgia.

EMCRO: Received report on 14 hospitals participating in hospital data system and potential conflict with Blue Cross' CHIP data system.

AMA: Recommended to AMA delegation that they oppose direct representation for specialty societies in the AMA House of Delegates.

Medicaid: Received report on negotiations with Prudential for assumption of claims processing for Medicare-Medicaid patients and removal of 90 day limit on submission of claims, now allowing up to 24 months.

Malpractice Insurance: Received report on Crum and Forster Coverage availability beyond $1 million for anesthesiologists having basic St. Paul coverage. Directed Insurance Committee to investigate other sources of malpractice coverage.

AAFMC: Endorsed F. William Dowda, M.D., Atlanta, for president of the American Association of Foundations for Medical Care.

Next Meeting: May 9, 1974, DeSoto Hilton, Savannah.

Status of Medical Legislation Following the 1974 Georgia General Assembly

RUSTY KIDD, *Atlanta**

The following is a summary of a portion of the legislation on which MAG took positions during the 1974 Session of the General Assembly. As of this writing, none of these bills had been signed into law by the Governor who had until March 28 to sign, veto or permit bills to become law without his signature.

DURING THE 1974 LEGISLATURE approximately 2,000 bills were introduced. Add to this number the 1,000 bills carried over from the 1973 session and the sum of 3,000 bills is reached that could be acted upon this year. MAG took an interest in 92 pieces of legislation, and the following 35 are representative of the areas in which the Association was involved. Those desiring a copy of or additional information on any of the bills should contact MAG headquarters.

Bills Passed During the 1974 Session

NEWBORN INSURANCE COVERAGE (H.B. 995): MAG supported. Bill prohibits insurance companies that write newborn coverage from excluding the first 14 days of life; therefore, for all policies that include newborn coverage, this coverage would begin at the moment of birth.

MATERNAL HEALTH COUNCIL (S.B. 649): MAG supported. Expands the Maternal Health Council to include the same number of pediatricians as obstetricians.

SPEECH PATHOLOGY AND AUDIOLOGY (H.B. 1342): MAG supported. The bill would create a Board of Examiners for speech pathology and audiology to regulate practices of both. DeKalb County Medical Society, Representative Robin Harris and others put much work on this bill last summer and helped tremendously in seeking its passage.

HOSPITAL AUTHORITY—TO CLARIFY MEANING OF TERM "PROJECT" (H.B. 1419): MAG supported. This bill adds to the definition of the word "project" doctors' buildings. Therefore, definition of the word "project" under the hospital authority includes the "acquisition, construction and equipping of hospitals, sanitariums, dormitories, office buildings, clinics, *doctors' buildings,* housing accommodations, nursing homes, rehabilitation centers, extended care facilities and other public health facilities for use of patients and employees." One effect of this is that all property owned by a hospital authority is public property so as to be exempt from ad valorem taxation.

CIVIL DEFENSE ACT—GOOD SAMARITAN LAW (H.B. 1507): MAG supported. A bill passed the Georgia Legislature in 1973 that by some interpretations was in direct conflict with the very good Georgia Good Samaritan Law. H.B. 1507 simply repeals that part of the law passed last year to keep Georgia's Good Samaritan Law intact.

GEORGIA ANATOMICAL GIFT ACT—DONOR'S DEATH (H.B. 1560): MAG supported. This bill requires the Department of Public Safety to provide forms for the gift of all or part of a person's body conditioned upon the death of the donor to appear on the donor's driver's license.

MEDICAL RECORDS—CONFIDENTIAL AND PRIVILEGED (H.B. 1657): MAG supported. This bill provides that a confidential or privileged medical matter which constitutes a record kept by a health care facility or physician does not lose its confidential and privileged character when disclosed in certain circumstances and that persons who are parties to disclosure of such medical matter shall be immune from liability under certain circumstances.

COMMON DAY OF REST, SET ASIDE ONE DAY—CONDUCTING BUSINESS (H.B. 974): This bill would limit the conducting of business on one of the two consecutive days of Saturday and Sunday. As originally introduced the bill excluded hospitals and nursing homes but had no clause to exclude physicians who practice in their office or physicians making house calls, etc. Amendments were made so that physicians could practice at will on Saturday and Sunday as they have always done in the

* Mr. Kidd has just completed his second season as legislative representative for the Medical Association of Georgia.

past. Except for other groups that were also excluded, all businesses have to close for one 24-hour period from midnight Friday night to midnight Sunday night.

ALCOHOLISM AND INTOXICATION TREATMENT CENTERS (S.B. 330): MAG supported. This bill, introduced in 1973, underwent numerous changes during the summer and the 1974 Legislature. Much was added by the Medical Association of Atlanta with cooperation of the MAG Committee on Mental Health. Briefly summarizing this 24 page bill, the state would appropriate money to build alcoholic treatment centers. Once these centers are built, instead of alcoholics being arrested and carried to jail for public drunkenness, thus having a police record, they would be taken to alcoholic treatment centers and given proper medical treatment rather than criminal treatment.

UNIFORM NARCOTIC DRUG ACT (S.B. 495): MAG supported. S.B. 495 is a 50 page bill which updates all controlled substances and reclassifies Schedules I, II, III, IV and V drugs. It allows the Board of Pharmacy to administer all parts of this law or reschedule all substances in this chapter pursuant to the Georgia Administrative Procedure Act. S.B. 495 further sets out classification of act in terms of punishment for violations according to the act or the schedule in which the controlled substance is listed. This bill goes into much more depth than space permits here. If anyone wishes a copy of the bill and a summary of the bill, please notify MAG Headquarters.

MEDICAL PRACTICE ACT (S.B. 612): MAG supported. This bill includes amendments to the existing Medical Practice Act. S.B. 612 was sponsored by the Composite State Board of Medical Examiners. In essence, these amendments would:

1. authorize the Board to carry out investigations either by itself or through the Joint Secretary and to employ a permanent staff of investigators if needed;
2. change the requirement that regular meetings for examinations be held in Atlanta and Augusta and would leave meetings to the Board's discretion;
3. authorize the Board to ask specific questions about a physician's qualifications to practice medicine each year when he applies for a license renewal;
4. redefine the grounds upon which a physician may be disciplined and the procedures to be followed by the Board in so doing;
5. after a physician has violated a provision, allow the Board to (a) refuse to license an applicant, (b) issue a private or public reprimand to the physician, (c) suspend a license for a set period, (d) restrict a license, (e) revoke a license, (f) condition or withhold doing any of these things if a physician will submit himself to professional care;
6. permit the Board to reissue a license which it has previously revoked under either present or antecedent law;
7. give the Joint Secretary the power to start investigations concerning a physician if a district attorney believes there may be some wrongdoing;
8. permit any record a physician may have made in regard to a patient to be admissible to the Board in a hearing to determine the physician's fitness to practice medicine;
9. empower the Board to issue a provisional license to an applicant, otherwise qualified, but before passing the required examination, allowing him to practice medicine only in an area the Board determines to have a shortage of doctors.

The original version of S.B. 612 contained two controversial sections dealing with nurses. These sections were deleted at MAG's request to be further studied during the summer months.

PHARMACISTS, PHARMACY AND DRUGS, INFORMATION ON PRESCRIPTIONS (S.B. 613): MAG supported. This bill states who and only who can write a prescription in Georgia. They are "physicians, dentists, veterinarians or any other person directly authorized by statute to prescribe drugs" (podiatrists) "in connection with medical treatment to the extent provided by the laws of the state." No person other than a practitioner of the healing arts may prescribe a dangerous drug. Practitioner being defined as physician, dentist, veterinarian or podiatrist.

NURSING HOME CERTIFICATE OF NEED (S.B. 16): This bill introduced last year passed the House of Representatives in an amended form to include both nursing homes and hospitals. During the '74 session this bill was changed back to its original form as introduced by the Georgia Nursing Home Association. S.B. 16 sets up a board to review applications and to issue a certificate of need for any expansion or new construction of nursing homes in Georgia.

DENTAL SURGEON INSURANCE COVERAGE (S.B. 153): This bill, also introduced during the 1973 session, did not pass last year, and after careful study and scrutiny by MAG and its attorney, we felt this bill, if not amended, would not infringe upon the breach of contract theory of insurance coverage which MAG has long supported.

Before a vote on this bill came during this session of the House of Representatives, an unsuccessful attempt by chiropractors to tack on an amendment to include themselves was tried. After this amend-

ment was overwhelmingly defeated, the bill passed. If signed by the governor, it would permit dental surgeons to be paid by insurance companies for their oral surgery work the same as physicians.

PUBLIC HEALTH STUDY COMMITTEE (S.R. 300): MAG supported. This resolution authorized the governor to appoint 10 members to a committee to study state laws relating to public health and to prepare legislation necessary to compile, clarify and codify state laws relating to public health. Composition of this committee will include members of the Senate, members of the House of Representatives, a member of the Georgia Public Health Physicians Association, a representative of MAG and others appointed at large by the governor.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION (S.R. 301): MAG supported. This resolution passed both the House and the Senate without one dissenting vote. S.R. 301 authorizes and directs the Secretary of State to transmit a copy of this resolution to the Secretary of the Senate of the United States, to the Clerk of the House of Representatives of the United States and to each member of the Georgia Congressional delegation. The resolution requests Congress to repeal the Professional Standards Review Organization Law as quickly as possible to prevent the damage it will cause to the public and to the American health care system.

Bills Defeated During the 1974 Session

HEALTH & WELFARE MERGER (H.B. 360): MAG opposed. This bill passed the House of Representatives during the 1973 session, was studied extensively by the Senate EREG Committee during the summer and was voted down 9 to 2 in Committee during the first week of the 1974 session. This bill was an attempt to consolidate on a county level the county Health and Welfare boards.

CERTIFICATE OF NEED (H.B. 504): MAG opposed. This bill passed the House of Representatives during the 1973 session, was studied by the Senate Health & Welfare Committee during the interim and was voted down overwhelmingly by the Senate committee during the 1974 session. This bill, if passed, would have set up a system whereby the Board of Human Resources would have the authority to say where and by whom every hospital in Georgia could be built. This, in effect, is contradictory to the freedom of choice concept Georgia has long thrived upon.

ACUPUNCTURE (H.B. 1360): MAG was neither in favor of nor against this bill but felt it was

Rondomycin®
(methacycline HCl)

CONTRAINDICATIONS: Hypersensitivity to any of the tetracyclines.
WARNINGS: Tetracycline usage during tooth development (last half of pregnancy to eight years) may cause permanent tooth discoloration (yellow-gray-brown), which is more common during long-term use but has occurred after repeated short-term courses. Enamel hypoplasia has also been reported. **Tetracyclines should not be used in this age group unless other drugs are not likely to be effective or are contraindicated.**
Usage in pregnancy. (See above **WARNINGS** about use during tooth development.)
Animal studies indicate that tetracyclines cross the placenta and can be toxic to the developing fetus (often related to retardation of skeletal development). Embryotoxicity has also been noted in animals treated early in pregnancy.
Usage in newborns, infants, and children. (See above **WARNINGS** about use during tooth development.)
All tetracyclines form a stable calcium complex in any bone-forming tissue. A decrease in fibula growth rate observed in prematures given oral tetracycline 25 mg/kg every 6 hours was reversible when drug was discontinued.
Tetracyclines are present in milk of lactating women taking tetracyclines.
To avoid excess systemic accumulation and liver toxicity in patients with impaired renal function, reduce usual total dosage and, if therapy is prolonged, consider serum level determinations of drug. The anti-anabolic action of tetracyclines may increase BUN. While not a problem in normal renal function, in patients with significantly impaired function, higher tetracycline serum levels may lead to azotemia, hyperphosphatemia, and acidosis.
Photosensitivity manifested by exaggerated sunburn reaction has occurred with tetracyclines. Patients apt to be exposed to direct sunlight or ultraviolet light should be so advised, and treatment should be discontinued at first evidence of skin erythema.
PRECAUTIONS: If superinfection occurs due to overgrowth of nonsusceptible organisms, including fungi, discontinue antibiotic and start appropriate therapy.
In venereal disease, when coexistent syphilis is suspected, perform darkfield examination before therapy, and serologically test for syphilis monthly for at least four months.
Tetracyclines have been shown to depress plasma prothrombin activity; patients on anticoagulant therapy may require downward adjustment of their anticoagulant dosage.
In long-term therapy, perform periodic organ system evaluations (including blood, renal, hepatic).
Treat all Group A beta-hemolytic streptococcal infections for at least 10 days.
Since bacteriostatic drugs may interfere with the bactericidal action of penicillin, avoid giving tetracycline with penicillin.
ADVERSE REACTIONS: Gastrointestinal (oral and parenteral forms): anorexia, nausea, vomiting, diarrhea, glossitis, dysphagia, enterocolitis, inflammatory lesions (with monilial overgrowth) in the anogenital region.
Skin: maculopapular and erythematous rashes; exfoliative dermatitis (uncommon). Photosensitivity is discussed above (See **WARNINGS**).
Renal toxicity: rise in BUN, apparently dose related (See **WARNINGS**).
Hypersensitivity: urticaria, angioneurotic edema, anaphylaxis, anaphylactoid purpura, pericarditis, exacerbation of systemic lupus erythematosus.
Bulging fontanels, reported in young infants after full therapeutic dosage, have disappeared rapidly when drug was discontinued.
Blood: hemolytic anemia, thrombocytopenia, neutropenia, eosinophilia.
Over prolonged periods, tetracyclines have been reported to produce brown-black microscopic discoloration of thyroid glands; no abnormalities of thyroid function studies are known to occur.
USUAL DOSAGE: Adults—600 mg daily, divided into two or four equally spaced doses. More severe infections: an initial dose of 300 mg followed by 150 mg every six hours or 300 mg every 12 hours. Gonorrhea: In uncomplicated gonorrhea, when penicillin is contraindicated, 'Rondomycin' (methacycline HCl) may be used for treating both males and females in the following clinical dosage schedule: 900 mg initially, followed by 300 mg q.i.d. for a total of 5.4 grams.
For treatment of syphilis, when penicillin is contraindicated, a total of 18 to 24 grams of 'Rondomycin' (methacycline HCl) in equally divided doses over a period of 10-15 days should be given. Close follow-up, including laboratory tests, is recommended.
Eaton Agent pneumonia: 900 mg daily for six days.
Children—3 to 6 mg/lb/day divided into two to four equally spaced doses.
Therapy should be continued for at least 24-48 hours after symptoms and fever have subsided.
Concomitant therapy: Antacids containing aluminum, calcium or magnesium impair absorption and are contraindicated. Food and some dairy products also interfere. Give drug one hour before or two hours after meals. Pediatric oral dosage forms should not be given with milk formulas and should be given at least one hour prior to feeding.
In patients with renal impairment (see **WARNINGS**), total dosage should be decreased by reducing recommended individual doses or by extending time intervals between doses.
In streptococcal infections, a therapeutic dose should be given for at least 10 days.
SUPPLIED: 'Rondomycin' (methacycline HCl): 150 mg and 300 mg capsules; syrup containing 75 mg/5 cc methacycline HCl.

Before prescribing, consult package circular or latest PDR information.

Rev. 6/73

WALLACE PHARMACEUTICALS
CRANBURY, NEW JERSEY 08512

a useless attempt to pass additional legislation that was unnecessary. The bill simply restated what the Attorney General has already ruled—that anyone puncturing the skin would be practicing medicine and therefore subject to a misdemeanor for practicing medicine without a license. Therefore, dentists and physicians can use acupuncture at their discretion under the current ruling of the Attorney General of Georgia.

MATERNITY CARE INSURANCE COVERAGE (H.B. 1362): MAG supported this bill in concept but felt it was almost impossible to pass. This bill would mandate each and every health insurance contract written in Georgia to include the maternity care package, thus covering the mother from point of conception until dismissal from hospital. Many insurance companies offer this coverage today; the estimated cost per policy for this coverage is not known but could conceivably run into many dollars per policy per month.

ABORTION (H.B. 1442): This was another unsuccessful attempt by the Georgia Right for Life group not only to alter the existing abortion laws in Georgia but to make them contrary to the Supreme Court ruling regarding abortion. MAG opposed this bill and sought its defeat. Therefore, the abortion law in Georgia remains the same as passed in the 1973 session, sponsored by MAG, which simply states that during the first trimester all abortions have to be performed by a licensed physician in Georgia. During the second trimester all abortions have to be performed by a licensed physician in a licensed clinic or hospital. During the third trimester all abortions have to be performed by a physician with a concurrence of two consulting physicians that said abortion is for the best health of the mother.

OPTOMETRY FREEDOM OF CHOICE (H.B. 1805): MAG opposed. This bill would prohibit anyone from discriminating against optometrists in regard to treatment of the eye. MAG, along with the Georgia Ophthalmology Society, vigorously opposed this legislation for a number of reasons. Under Georgia law optometrists are only licensed to fit refracted lenses and are not licensed, trained or qualified to diagnose or treat eye diseases. If this bill had passed, it would not give them authority to treat eye diseases but would give them an opportunity to do so without proper referrals to MDs. Through the efforts of ophthalmologists throughout Georgia, with the assistance of many interested MAG members, contact was made both personally and by phone with all members of the Senate and Lieutenant Governor Maddox seeking defeat of H.B. 1805. This bill passed the House of Representatives and passed the Senate Health and Welfare Committee but was never called for a vote in the Senate and in essence was defeated this year.

COUNTY HEALTH BOARD (H.B. 1809): This is a very short, one page version of House Bill 360 mentioned earlier which would authorize and direct county boards of health, county boards of family and children's services, and their respective departments to take the necessary action to insure full and complete cooperation between all county departments. MAG opposed this bill as it did H.B. 360 and sought its defeat.

PSYCHOLOGY INSURANCE (H.B. 2001): MAG opposed. This was another bill which would breach an individual's right of contract as far as insurance policies go, very similar to what the chiropractors tried last year, which would mandate that psychologists be covered on all health and accident insurance policies. As with the chiropractic bill, H.B. 2001 was defeated.

AMBULANCE LEGISLATION (H.B. 1608, 1761, 1811, S.B. 568, S.R. 299): All five of these pieces of legislation were defeated this year. All had to do with the Georgia Ambulance Service Act, emergency services, etc. to alter the present existing law in some form or fashion. The MAG Legislative Committee along with MAG Rural Health Committee felt that these bills would greatly hinder the good programs that have been set up in the past. Therefore, our position was against these bills, and fortunately, none passed this session.

STATE HOSPITAL ADMINISTRATOR (S.B. 222): MAG supported this bill which would *reclarify* existing Georgia law and would specifically state that the superintendent or administrator of any state operated mental institution would have to be a physician. Governor Carter had stated that if this bill passed, it would be vetoed. Still this bill passed the Senate and through much deliberation, confusion, excitement and controversy, was defeated in the House Health and Ecology Committee. Let me restate, however, current existing law which is under study by the Attorney General's office today says that the superintendent of all mental hospitals has to be a doctor of medicine.

REINSTATEMENT OF MEDICAL LICENSE —CRIMINAL CONVICTION (S.B. 427): MAG opposed this bill which states that after a medical license had been revoked as a result of the holder's being convicted of a felony, the license could not be reinstated by the Board of Medical Examiners at any time. MAG felt that if a license was revoked due to

a felony and said individual went through a rehabilitative process, then if the Board deemed fit to reinstate his license, it should be done.

REVOCATION OF MEDICAL LICENSE (S.B. 546): This bill is similar to S.B. 427 referred to previously. However, S.B. 546 requires refusal or revocation of license upon second conviction of a felony. This bill was defeated due to the penalty clauses and the amendments to the Medical Practice Act previously mentioned in S.B. 612. However, had this bill passed, it would have set up the State Board of Medical Examiners as direct agent to the Georgia General Assembly in acting on every bill passed by the Legislature.

NARCOTIC DRUG PRESCRIPTION—PHYSICAL EXAMINATION REQUIRED (S.B. 547): As this bill was originally introduced, it stated no physician could dispense or write a prescription for narcotic drugs without giving a patient a physical examination. MAG opposed this bill in its original state and suggested amendments to it which were a required physical examination within the previous five years and only if relating to Class II narcotics. With these amendments the bill was more acceptable but was still not preferred. This bill passed the Senate but failed overwhelmingly in the House of Representatives.

HYPNOTISM (H.B. 370): This bill was introduced as part of MAG's packet during the 1973 Legislature when it passed the House of Representatives and was being studied in the Senate Institutions and Mental Health Committee. Early in the session this year there was a hearing on this bill and it passed out of the Committee but was later recommitted at the request of several senators. It was never reported out again, thus was defeated. MAG will try again in 1975 to pass a similar bill to H.B. 370 which states that only physicians and dentists may use hypnotism in their respective practices.

Doctor-of-the-Day

This program continues to be MAG's best public relations endeavor. Some 320 members of the House and of the Senate, at one time or another, visited the Medical Aid Station during the session. This year a full time nurse, Mrs. Kathy Yarborough, was hired by MAG to staff the station. She won much praise by the General Assembly and resolutions passed both chambers commending her. It would be a benefit to MAG if she could be hired again next year, and all members owe her a debt of gratitude for her efforts. Her address is available through MAG headquarters.

Thank You

The efforts on the part of many of you enabled MAG to have a most prosperous legislative year. *No* bills were passed which MAG opposed. Two bills failed which MAG supported—neither of the two were vital pieces of legislation. This success can only be attributed to you, interested MAG members, contacting your individual legislators in an effort to assist the MAG staff in reaching a common legislative goal.

This year is a campaign year. As of this date, there are eight candidates for governor and six candidates for lieutenant governor. I personally know of 10 senators and 18 representatives who are not going to run. Add these to the 22 per cent turnover every election and there will be in 1975 a new governor, a new lieutenant governor and probably 85 new legislators.

It is of vital interest to you as a Georgian, as a taxpayer and as a physician to coordinate efforts with MAG, pick a candidate for both local and state office and help him to be elected.

The MAG staff is at your service. ■

FAMILY PRACTICE EXAMINATION ANNOUNCED

The American Board of Family Practice announces that it will give its next two-day written certification examination October 19-20, 1974. The examination will be held in five centers geographically distributed throughout the United States. Information regarding the examination may be obtained by writing:

Nicholas J. Pisacano, M.D., Secretary
American Board of Family Practice, Inc.
University of Kentucky Medical Center
Annex #2, Room 229
Lexington, Kentucky 40506

Please note: It is necessary for each physician desiring to take the examination to file a completed application with the Board office. Deadline for receipt of applications is June 15, 1974.

This method has been demonstrated to be a rapid, simple, safe and effective technique of sterilization.

The Georgia Regional Laparoscopic Sterilization Program: A Preliminary Report

EDWIN S. BRONSTEIN, M.D., M.P.H., *Augusta**

According to the 1970 National Fertility Study,[1] the most common method of contraception among couples over 30 years of age in the United States is sterilization by tubal ligation in the female or vasectomy in the male. Many alternatives are available to the woman selecting sterilization as a method of contraception. These methods include post-partum tubal ligation, hysterectomy, vaginal tubal ligation, culdoscopic, hysteroscopic and laparoscopic procedures. Modern sterilization procedures such as laparoscopy can provide a rapid, effective and safe operation at low cost, for the woman electively seeking sterilization.

Laparoscopy was first used by Bernheim[2] in the United States in 1911 and Ruddock[3] in 1930 reported some 200 cases performed under local anesthesia. In 1937,[4] the first laparoscopy tubal cauterization was performed but it was not until Palmer[5] and others[6] reported this procedure, that its use became more popular. The advent of fiberoptics, the operating laparoscope, the use of pneumoperitoneum and the Trendelenburg position have made the operation a rapid, simple and effective procedure.

Uses of Laparoscopy

Laparoscopy has many uses which are both diagnostic and therapeutic. Some of its uses are in the work-up of the infertile patient as well as in the diagnosis of ectopic pregnancy, endometriosis and chronic pelvic pain. Therapeutically it can be used to lyse adhesions, treat endometriosis and do tubal coagulation and division.

Laparoscopy can be performed through one or two incisions under local or general anesthesia, as an in-patient or an out-patient. This flexibility has provided the opportunity of developing elective laparoscopic tubal coagulation and division as an out-patient procedure. The failure rate is about 3 per 1,000[7] cases with the complication rate being approximately 6 per 100.[8] Complications of laparoscopic tubal coagulation are related to the development of the pneumoperitoneum, the anesthesia and the electrocoagulation procedure. Complications include perforation of bowel, arrhythmias, burns of the skin and bowel, and failure of the operation. The high degree of success with a low complication rate; the short hospital stay for a procedure which provides immediate, permanent (but not absolute) contraception has gained increasing interest of women who desire voluntary sterilization.

At the present time, a small percentage of physicians in Georgia and other areas of the United States have been trained in this procedure. The need to provide this operation as an alternative to patients electively seeking sterilization brought about the creation of the Georgia Regional Laparoscopic Sterilization Program in January of 1973. Supported by a contract from the Department of Human Resources, under a grant from the National Center for Family Planning Services, the goal of this program is to train physicians and hospital staff throughout the State of Georgia so that more hospitals would have this procedure available for patients. The second objective was to make more people aware of this operation; its availability, low cost, high success and low complication rate, so more women could select this procedure.

The American College of Obstetricians and Gynecologists recognized the need for guidelines in the performance of laparoscopy and issued a statement

* Associate professor in the Department of Obstetrics and Gynecology, chief of the Division of Maternal Health and Family Planning, Medical College of Georgia in Augusta 30902. This report was supported by a contract from the Department of Human Resources under Grant #04-H-000-462-02-0 from the National Center for Family Planning Services.

in May 1973.[9] They recommend the procedure be undertaken in a hospital or in a specially equipped and accredited out-patient facility. The physician performing the procedure must have the requisite background to manage complications arising from anesthesia or entry into the peritoneal cavity. The physician should, in order to be qualified to perform gynecologic laparoscopy: a) have unrestricted privileges in major gynecologic surgery in an accredited hospital, and b) have demonstrated competence in the technique of laparoscopy.

Description of the Operation

At the Eugene Talmadge Memorial Hospital, patients can have laparoscopic tubal coagulation and division as in-patients or out-patients. Out-patients are selected only if they are Class I patients according to the guidelines of the American Society of Anesthesiologists. These are patients with no medical or surgical complications, are in good health and have followed all pre-operative instructions. All patients are seen by a team consisting of a physician, social worker and clerk. A detailed history is completed by the patient with the assistance of a clerk. The patient, and preferably the couple, are then counseled by a social worker who attempts to define whether or not the couple have made a mature decision. Emotional conflicts and problems which may be the primary motivation for a sterilization operation are, hopefully, uncovered and dealt with before any final decision for surgery is made.

Each couple is then made aware of alternative methods of sterilization as well as the sterilization law of the State of Georgia. In Georgia any couple can have a sterilizing operation with the consent of the spouse. Any person unmarried may have a sterilizing operation if they are over 18 years of age. A separate and more detailed procedure is associated with a request to sterilize a minor or someone who is mentally retarded. This procedure includes the consent of parents or kin or a court appointed legal guardian; examination by two physicians attesting to the mental retardation of the person; approval by the judge of the Court of the Ordinary; performance at a hospital which has been approved by the Joint Committee on Accreditation for Hospitals and in which a sterilization committee of three physicians at that hospital agree. A sixth physician then performs the operation after it has been approved by the Court of the Ordinary.

After the patient and/or couple have been counseled by the social worker, they are seen by the physician who reviews the history as well as the report of counseling. A description of the laparoscopic operation as well as additional counseling when necessary are provided by the physician. A complete physical examination rules out any medical, surgical or gynecological problem that would necessitate more definitive surgery such as a hysterectomy. The complete process is reviewed with the patient and/or couple and a decision is made for or against surgery. The patient having a laparoscopic tubal coagulation and division, has a CBC, urinalysis, pap smear and gonorrhea culture.

The patient will be seen by the anesthesiologist in consultation prior to the out-patient procedure. The patient arrives at the hospital having eaten nothing by mouth with specific instructions and a responsible adult who will be present at the time of discharge. The patient is taken to the operating room where she may or may not be pre-medicated. The anesthesia management varies; most patients receive atropine, Pentathol®, induction, Innovar®, succinylcholine, nitrous oxide and oxygen. This balanced anesthesia includes intubation of the patient. The physician or his assistant places a uterine manipulator in the cervical canal to facilitate mobility of the uterus during the operative procedure. A Verres needle is introduced through a one centimeter incision in the umbilicus or immediately infra-umbilically. Through this needle, a pneumoperitoneum is developed, instilling about 3000 cc of carbon dioxide into the abdominal cavity. This flows at a rate of one liter per minute, never exceeding 12 to 15 millimeters of mercury, intra-abdominal pressure.

Following the pneumoperitoneum, a trocar and cannula are introduced through the same incision, followed by the insertion of the operating laparoscope. A one incision technique is presently used at the Eugene Talmadge Memorial Hospital. Through the operating laparoscope, a biopsy forceps, 3 mm in diameter is introduced and each tube is grasped approximately 1 to 2 cm from each cornu of the uterus and both tubes are coagulated and divided in two different places. One is careful that when the coagulation is performed there is no proximity to bowel. The operative procedure lasts approximately 20 to 25 minutes without the additional time of teaching. The patient then spends approximately one and a half hours in the recovery room, followed by two hours in a holding area from which she can be discharged to her home.

The post-operative period is marked by a washed out feeling for 24 to 36 hours, and some abdominal and shoulder discomfort. The patient usually returns to work or normal activities within 72 hours and requires, at the most aspirin for her discomfort. Each patient is seen at two weeks, six weeks and six months for follow-up visits. For patients who require

hospitalization, they are admitted one morning, operated on the following day and discharged that evening or the following morning. Average hospital costs are approximately $150 for an out-patient procedure and $250 for an in-patient procedure.

Training Program

To effect the goal of the Georgia Regional Laparoscopic Sterilization Program, physicians and hospital operating room staff will be trained both at the Medical College of Georgia and in the local community hospitals. Two day training programs have been arranged starting in September of 1973 at the Eugene Talmadge Memorial Hospital. The training includes a day of education, personalized instruction, the use of a self-instructional manual for laparoscopy and practice sessions. Day two involves observation and participation in the operating room with the training staff. Two physicians and two nurses will be accepted to each program.

Requests for training at the community hospital are also being accepted and a team of a physician and operating room technician, skilled in laparoscopy, will visit the local hospital at no cost to the institution. The team will spend two days with the physicians and hospital staff. Day one being an education day, the training staff will bring educational materials, the self-instructional laparoscopic manual and a model for practice, as well as the instruments necessary for the operative procedure. In preparation for day two, it is hoped that the local physicians will arrange for patients who desire elective sterilization to be scheduled so that the visiting training team can operate with the local physician. Follow-up visits will be made to the community hospital for continued education of the physicians and nurses.

The goal of the program is to establish laparoscopic centers throughout the state so that each area network will have at least one hospital facility where these procedures can be carried out. A recent telephone survey of hospital operating room head nurses was carried out to determine the degree of laparosopic activity throughout the state of Georgia. Of 158 hospitals surveyed, 148 were contacted (93 per cent) and 36 (24 per cent) either owned equipment or carried on laparoscopy.

In March of 1973, the State Department of Human Resources developed a program for payment for elective sterilization for patients who did not have Medicaid and who could not afford a sterilizing operation. Because of a cut-back in federal funds, this program has had a moratorium placed upon it as of July 1, 1973. It is hoped that funds will again become available so that patients who cannot afford the operation will have funds available to pay hospital and physician bills.

Conclusion

To meet the rising needs of couples selecting sterilization as a permanent method of contraception, the Georgia Family Planning Program has instituted a Regional Laparoscopic Sterilization Program at the Medical College of Georgia which includes the provision of services and the training of physicians and hospital nursing staff throughout the State of Georgia to promulgate this goal. At the present time only 36 (24 per cent) of 148 hospitals surveyed in Georgia presently do laparoscopy. Laparoscopic tubal coagulation and division has been demonstrated to be a rapid, simple, safe and effective method of sterilization for the woman who selects a permanent method of contraception.

I wish to gratefully acknowledge the work of Mrs. Mattie Lawson and Ms. Toni Cooke.

Addendum

Since the submission of this article for publication, the American Association of Gynecological Laparoscopists reported a failure rate of 0.9 per 1000 cases and a complication rate of 6 per 1000 cases.

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editorials

An Obligation to Patient Education

IT IS RECOGNIZED that the bulk of this issue of the JMAG relates to continuing education for physicians. That this is desirable and necessary is unquestioned, but I feel that another form of "continuing education" is also essential. This is the education about health that continually must be given to the public.

It has been said that the best physician:patient ratio may be 1:1. Since this is patently absurd and impossible, and since it seems unlikely that we will ever achieve the number of physicians and other health personnel desired by the public at any given moment, one partial solution to the problem of health care delivery would seem to lie in the sphere of public education.

Unnecessary Utilization

It is estimated that about 80 percent of the average physician's office practice is a result of mild, self-limited physical illnesses or emotional disturbances brought on by the stresses of modern day life coupled with a lack of understanding of physical and emotional interactions on the part of the patient. If this is true, then increasing knowledge about health in general, and of the etiology and prognosis of human illness in particular, would go a long way toward alleviating this unnecessary utilization of medical care. Also it should bring about a more healthful, efficient, and effective management of one's personal life.

A report was issued in 1973 by the President's Committee on Health Education which followed over a year of activity, including public hearings and expert consultations on the status of health education in the United States today. I commend it to you for your considered reactions. In general the conclusions state that regardless of what changes or improvements in the delivery and financing of health care may occur in this country, they will be virtually nullified unless there is at the same time an improvement in health education. It emphasizes that this aspect of our national commitment toward a healthier population has been sorely neglected. Some statistics are interesting: approximately 92 per cent of the roughly $200 million a day spent in 1971 for medical, hospital, and health care was spent for treatment after illness occurred. About 5 per cent was spent on biomedical research. About 2½ per cent was spent on prevention of illness. And the remaining ½ per cent was spent on health education. When it is reasonably well accepted that health education and preventive measures can avoid much acute and chronic illness, it seems incredible that such a sophisticated population as ours should not emphasize more strongly these aspects of health care, and allocate more resources in their behalf.

The Responsibility of Many

There are many ways in which health education to the public can be increased effectively. Some of the ones that seem most appropriate to me, that need attention, and that can be effected, include the use of health

professionals in teaching health education in all primary school situations, particularly at the lower grades. Government, prepayment plans, and insurance companies should be willing to include in their premium rates the cost of health education for the patients involved. Hospitals and physicians' offices should be heavily involved in patient health education constantly. Healthful and safe living practices, on and off the job, should be promulgated more frequently and more effectively by business, industry, and labor groups. Health education courses should be a prominent part of all educational programs training health and allied health professionals, and educators and teachers.

Not only do we need to continue our own professional education as physicians so that we may keep up with the burgeoning changes in our medical and scientific world of today, but we also need to initiate and continue the health education of all people, from early childhood throughout life, for a more rewarding existence.

John Rhodes Haverty, M.D.

Grant Awarded to Emory Multiple Sclerosis Center

Emory University has been awarded a grant of $800,000 for the support of a Center for Research in Multiple Sclerosis and Related Diseases. The award, from the National Institute of Neurological Diseases and Stroke, covers a four-year period beginning February 1.

The Emory center is one of three in the United States, the others being at the University of Pennsylvania in Philadelphia, and the University of California at Los Angeles.

Multiple sclerosis is a disease seen in persons between the ages of 20 and 40. An estimated 500,000 Americans have MS or related disorders, and an estimated 2,000,000 family members are affected by its heavy economic burden, according to the National Multiple Sclerosis Society.

Herbert R. Karp, M.D., chairman of the Division of Neurology, Emory University School of Medicine, said the new center makes it possible for investigators from many different scientific disciplines to continue Emory's active research program in multiple sclerosis.

Robert F. Kibler, M.D., member of the Emory faculty since 1962, is director of the new center. Principal investigators working with Dr. Kibler include Dr. Raymond Shapira of the Department of Biochemistry, who together with Dr. Kibler has isolated and synthesized a protein which can produce a multiple sclerosis-like disease in experimental animals.

Dale E. McFarlin, M.D., neuroimmunologist, and Dr. David L. Camenga, neurovirologist, are actively investigating the concept that viruses in combination with the immune and inflammatory responses of the body may be responsible for diseases such as multiple sclerosis.

"Emory has been building toward the research center concept for several years," Dr. Karp said. "Financial support from the National Multiple Sclerosis Society and private sources has made this research possible. The present award from the Department of Health, Education and Welfare is a most gratifying recognition of the quality and importance of our research."

POPULARITY OF FAMILY PRACTICE SPECIALTY INCREASES

A survey of 1974 graduating medical students by the American Academy of Family Physicians shows that (1) more medical students than ever before are choosing family practice as their specialty, and (2) that the demand for first-year spaces in family practice residencies exceeds the number of spaces available by almost two to one.

The purpose of the study, conducted by the Academy's Education Division, was to determine what deficit —if any—existed in first-year spaces before the National Intern and Resident Matching Program (NIRMP) results are released.

Some 160 of the 191 approved residencies have responded so far. As of early February, these training units reported 2,014 graduates seeking first-year spaces. Estimated spaces available stand at about 1,170, leaving a deficit of 844 graduates desiring first-year spaces.

Dr. Robert Graham, assistant director of the AAFP Education Division, said residency directors have indicated to him that if enough financial and faculty support could be obtained, extra spaces might be created to absorb at least some of this deficit.

president's letter

An Honor I Would Not Relinquish



THIS IS MY FINAL EDITORIAL as President of the Medical Association of Georgia. It has been a tiring, stimulating, interesting, expensive year. A year I would not care to repeat, but an honor I would not relinquish for any sum. The MAG membership has been most cooperative and most understanding of my shortcomings.

We are financially solvent and our membership continues to grow. We have the most competent and efficient headquarters staff of any state society. Without their help and advice the Presidency would be an impossible task for a practicing physician. Because of our many activities such as the Georgia Regional Medical Program (GRMP), Experimental Medical Care Review Organization (EMCRO) and the Georgia Medical Care Foundation, we find ourselves short of headquarters floor space. I feel we should seriously consider the purchase of additional property to enable our physical plant to grow as the organization grows.

My final plea is that all should strive collectively to assure the continued growth and strength of organized medicine. As a strong, united organization, we can more efficiently and effectively stall or modify our government's continued meddling into our affairs. This activity alone will require more and more of our time and money.

Thank you all for the honor of the Presidency of our organization.



Charles Emory Bohler, M.D.
President, Medical Association of Georgia

heart page
heart page
heart page

Myocardial Revascularization Current Concepts in the Management of Ischemic Heart Disease (Part I)

ELLIS L. JONES, M.D., SPENCER B. KING, M.D. and
CHARLES R. HATCHER, JR., M.D., *Atlanta**

ALTHOUGH DIRECT CORONARY SURGERY has been employed for six years, controversy remains regarding the indications and results of myocardial revascularization for the treatment of patients with ischemic heart disease. Because the natural history of the patient with angina remains incompletely defined, indications for surgery have varied greatly throughout the country. Studies on the natural history of the patient with angina have indicated that the five year cardiac mortality rate was 34.4 per cent in 590 consecutive unoperated patients with coronary artery disease documented by coronary arteriography. The number of diseased vessels was the most important prognostic factor as indicated by the five year mortality rate of 14.6 per cent for patients with one vessel involvement, 37.8 per cent for patients with two vessel involvement, and 53.8 per cent for patients with three vessel involvement. For those with at least 50 per cent narrowing of the left main coronary artery, the five year mortality rate was 56.8 per cent. Although present data is insufficient to indicate the effectiveness of coronary artery bypass on patient longevity, preliminary data would indicate that survival is certainly no worse in the operated group. Regardless of the effect on survival the efficacy of direct coronary surgery for the relief of angina pectoris is widely recognized. Objective data is also available showing significant increase in postoperative exercise performance and reversal of ischemic electrocardiographic response. The following discussion elaborates on present concepts regarding the indications and management of the patient with ischemic heart disease.

Current Indications

Our current indication for myocardial revascularization is intractable angina pectoris unresponsive to vigorous medical management in a patient who at catheterization has one or more critical stenotic lesions with vessels distal to the block which are acceptable for bypass grafting. Such patients are accepted as operative candidates if left ventricular function is not severely impaired. Some importance is given to operating on those patients in whom the pain pattern is progressive, and in whom the angiographic lesions are critically located.

Intractable Angina Pectoris

Myocardial revascularization is most often performed in those patients with disabling angina or angina which markedly interferes with the patient's life style. Following coronary bypass grafting, 80 to 90 per cent will have marked symptomatic

* From the Divisions of Cardiology and Thoracic and Cardiovascular Surgery, Emory University School of Medicine, Atlanta, Ga. 30322. Part II will be published in the May *JMAG*.

improvement more than a year after operation. Fifty to 60 per cent are rendered completely asymptomatic following the procedure. The mortality rate in experienced hands is now less than 5 per cent. Clinical results correlate very closely with angiographic evidence of graft patency. Early patency of vein grafts in the first month after surgery is approximately 90 per cent. By the end of the first year another 15 per cent of grafts occlude. This correlates with an 80 per cent improvement rate at the end of one year. Correlation of clinical improvement and graft patency is further strengthened by improved tolerance to treadmill exercise testing.

A phenomenon of intimal and medial thickening may occur later in the postoperative period and in 5 per cent of patients this progresses to the point of luminal obliteration. The process may be related to pressure, turbulance, or ischemia in the wall of the graft. However, after the first year this process does not seem to occur and the patency rate of the grafts becomes stable. In the last several years an alternative to vein grafts has been the introduction of the internal mammary artery graft, primarily used in disease of the left anterior descending and circumflex coronary arteries. The early and late patency rate with the use of this vessel has been approximately 95 per cent. It is quite possible that the overall long term patency of the internal mammary artery graft will be superior to that of the saphenous vein graft. This is especially true in situations of very low flow rates (less than 40 ml/min.). *(Part II next month.)* ■

Six Facilities Receive HBP Project Funding

Six state medical facilities have received funding of approximately $15,000 each for the first six months of the Georgia Heart Association's Community High Blood Pressure Project, it has been announced by GHA President, Dr. Charles R. Hatcher, Jr.

HBP Centers are now underway in Athens, Atlanta, Augusta, Columbus, Savannah and Thomasville with funds available through June 30, 1974. The HBP centers project is being conducted in cooperation with the Georgia Regional Medical Program which is providing substantial funding for it, along with the American and Georgia Heart Associations. It is expected that centers will be refunded for another year up to July 1, 1975.

The HBP Centers are a part of the Heart Association's statewide "Project: HBP Control" to detect and bring under control the state's estimated 800,000 cases of high blood pressure (hypertension).

In Athens, Walter J. Brown, Jr., M.D., is project director for the program at Athens General Hospital, with Zeb L. Burrell, Jr., M.D., serving as collaborator.

Gerald F. Fletcher, M.D., will direct the project at Georgia Baptist Hospital in Atlanta and John Cantwell, M.D., will collaborate.

The Augusta Area High Blood Pressure Project, directed by Albert A. Carr, M.D., received funds to conduct the HBP Center project through two Augusta facilities, Talmadge Memorial Hospital and University Hospital. Louis L. Battey, M.D., serves as collaborator.

C. Dan Cabaniss, M.D., directs the Columbus project at The Medical Center, with Joanne Smith, M.D., as collaborator.

Savannah's Memorial Medical Center was another medical facility named with Zellner C. Young, M.D., as project director.

John D. Archbold Memorial Hospital in Thomasville will operate an HBP Center under direction of Huddie L. Cheney, M.D. Oscar M. Mims, M.D., will collaborate.

Consent to Medical Treatment

J. WINSTON HUFF, *Atlanta**

In 1972, the Georgia General Assembly enacted a law reducing the age of majority from 21 to 18 years. A number of calls to MAG headquarters indicates a question in the minds of physicians as to the effect this new law will have upon consent to medical treatment by patients in the 18-21 year age group.

As a matter of fact, since 1971, we have had in Georgia a comprehensive medical consent law which covers many problem areas, including the newly emancipated 18 year olds. This article will set forth briefly the principal provisions of the medical consent law.

Persons Legally Authorized

In most cases, any one of the following is legally authorized to consent to medical or surgical procedures or treatment not prohibited by law which may be recommended, prescribed or directed by a duly licensed physician:

(a) Any adult, for himself;
(b) Any parent, for his minor child;
(c) Any married person, for himself and for his spouse;
(d) Any person temporarily standing in the place of a parent, whether formally serving or not, for a minor under his care, and any guardian for his ward;
(e) Any person 18 years of age or over, for himself;†
(f) Any female, for herself, when given in connection with pregnancy, or the prevention thereof, or childbirth;
(g) In the absence of a parent, any adult, for his minor brother or sister;
(h) In the absence of a parent, any grandparent for his minor grandchild.

The foregoing relationships include the adoptive, foster and step-relations and the relationship by common law marriage as well as by ceremonial marriage.

By the same token, any person 18 years of age or older has the right to refuse to consent to treatment.

A physician acting in good faith is justified in relying on the representation of any person purporting to give such a consent including, but not limited to, his identity, his age, his marital status and his relationship to the patient for whom the consent is given. A consent is presumed to be valid, unless obtained by means of fraudulent misrepresentations, if it is in writing, is signed by the patient or other person authorized to consent, and discloses in general terms the treatment or course of treatment in connection with which it is given.

Abortions, Sterilization

As has been discussed in a previous article in the *Journal,* there is a special

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* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, Atlanta, Ga. 30303.

† This law was on the books prior to the 1972 law dealing with 18 year olds.

statute which must be followed for abortions after the second trimester. There is also a special statute and a special procedure to be complied with for sterilization of a person of any age with mental retardation, brain damage, or both. A physician may sterilize any person 21 years of age or older, or if less than 21 years of age, if that person is legally married, upon the written request of such person and of his or her spouse. This latter consent presumes mental competency and would not obtain in the case of mental retardation, brain damage, etc. The doctor must give a full and reasonable medical explanation as to the meaning and consequence of the sterilization operation.

The consent of a minor (now a person under 18 years of age) who is or professes to be afflicted with a venereal disease, or is or professes to be suffering from drug abuse, is valid and binding for any treatment involving procedures and therapy related to conditions or illnesses arising out of these causes.

Emergency Situations

A consent to treatment by a licensed physician is implied where an "emergency" exists. An emergency is defined as any situation wherein the proposed treatment or procedures are reasonably necessary in competent medical judgment and a person otherwise authorized to consent is not readily available and any delay in treatment would reasonably be expected to jeopardize the life or health of the person affected or could reasonably result in disfigurement or impairment of faculties.

The new 1972 law reducing the age of majority to 18 affects several areas which the physician must watch. Now a parent cannot give a legally binding consent for his child who has attained 18 years of age. Also, in the absence of the parent, a person who is 18 or older can consent for a brother or sister who is under 18 years of age. Finally, parents are no longer financially responsible for the medical expenses of their children who are 18 years of age or older. Previously, this liability was present until the child was 21. Physicians concerned with the payment of bills of patients in the 18 to 21 year age group must either look to the resources of the patient himself, or must have the parents specifically agree in advance to assume responsibility for payment.

In every instance of doubt, the physician should consult his attorney. ■

J. WILLIS HURST WINS GIFTED TEACHER AWARD

J. Willis Hurst, M.D., professor and chairman of the Department of Medicine at Emory University School of Medicine, has received the 1974 Gifted Teacher Award of the American College of Cardiology. He was honored by the 5,800-member medical specialty society at its 23rd Annual Scientific Session February 13 in New York City.

Dr. Hurst, a widely known cardiologist and medical educator, served in 1972 as president of the American Heart Association. He is the author of many books and scientific articles on heart and blood vessel diseases. *The Heart,* a book he edited, is a standard textbook in this country, and is now in its third edition. Dr. Hurst is also co-author of two books on the problem-oriented system of medical practice and medical education.

He was graduated in 1944 from the Medical College of Georgia and was valedictorian. His internship and residency training were at the University Hospital in Augusta. In 1947-49 Dr. Hurst served as a cardiac fellow with Dr. Paul Dudley White at Massachusetts General Hospital in Boston, prior to coming to the Emory University School of Medicine in 1950. After serving from 1953-55 in the U.S. Navy, he returned to Emory as assistant professor of medicine, attaining his present post in 1957.

I've told this before . . . .

(Ed. note: You have to be quick to out fox a terrapin. Author J. G. McDaniel, M.D., of Atlanta found that trying to rescue a baby robin from the jaws of one such turtle took the skill of a surgeon. Others wishing to contribute to this feature page should send their writings to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Terrapin and Baby Robin

SOME SPRINGS BACK I was dressing for work and suddenly the birds changed their tempo from a merry happy song to one of concern. In the beginning it was just a warning song as girls in college cried out many years ago, "man on the hall!" Usually it was an old dog passing them and their babies were on the ground. It might be a cat just snooping around.

But soon the tempo changed, as in the Navy when general quarters were sounded and the captain came on and said, "This is no drill." Their captain, I do not know whether jay bird or robin, I think a robin, stated positively that this was no drill. I looked out of the upstairs window and saw them enthusiastically dive bombing something beyond our wall and all the birds were in a frenzy. I walked out to the wall and here was a four by three inch terrapin who had a baby robin by the foot and was trying to drag him in the brush about three feet away. He would back a few steps, then the robins would hit him. Of course, he would pull his head in and stop, and the robins had no target except his hard shell. But as soon as he moved, he was bombed again. All this time there was great chatter from all the Kingdom of Birds—fight!! fight!! fight!! they cried.

I went down and got Mr. Terrapin to keep him from getting into the brush, but he pulled his head into the shell with the baby's foot, and by the way, he had a firm grip. By this time the birds did not know who the enemy was. I hollered to Marguerite (my wife) to bring me an ice pick, a small butcher knife and a pair of pliers, which she did. Then I told her that I was going to stick the ice pick into the terrapin's neck and for her to hold the robin. When I had pried it out, I would grasp his head with the pliers and make him release the robin—but she wanted no part of this. She said that when the terrapin released the robin he might latch on to her finger, and even though I explained that this little terrapin had a very small mouth, etc., she saw that he could draw the robin's foot into his shell. And besides, she did not like the birds threatening her. Of course, the baby robin was crying all the time.

I, finally, with the ice pick, pliers, etc., pried the robin from the terrapin's mouth. He hopped off on one foot, about half way flying and then the parents took over. I never saw him afterward.

It never occurred to me that the little old terrapin that you see around your lawn and garden were carnivorous. I thought they ate vegetables and insects. But this one was smart enough to catch a baby robin. I know this, the length of their neck and the rapidity with which they can thrust their heads forward will amaze you.

J. G. McDaniel, M.D.

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SOCIETIES

Illinois psychiatrist and author of the book, "On Death and Dying," Dr. Elisabeth K. Ross addressed the **Georgia Medical Society** during a continuing education seminar February 12. Wives of members attended the evening session as special guests and St. Joseph's Hospital was host for the evening.

Bibb County president John O'Shaughnessey and delegate Jack Menendez recently discussed PSRO on the talk show "Close-Up" of television station WMAZ in Macon.

PERSONALS

First District

Robert B. Quattlebaum, Jr., Savannah, is the author of an article, "The Role of a Sickle Cell Center in Comprehensive Screening and Counseling for Sickle Cell and Related Disorders," which appeared in the March *Southern Medical Journal.*

Second District

James L. Story, Jr. of Thomasville has been certified as a Diplomate of the American Board of Surgery. Dr. Story has practiced in Thomasville since 1972 and is secretary-treasurer of the Thomas Area Medical Society.

Fifth District

J. Gordon Barrow, Atlanta, director of the Georgia Regional Medical Program, has been presented the American Heart Association's Award of Merit for outstanding service as chairman of the AHA's national Program Committee.

Several Atlanta physicians have been promoted recently at Emory University School of Medicine: **Charles A. Eberhart** to clinical professor of surgery; **Milton S. Goldman** to clinical assistant professor of surgery; **Hoyt C. Dees** to clinical associate in gynecology and obstetrics; and **James B. Lyon, Jr.,** to clinical assistant professor of gynecology and obstetrics.

Thomas E. Whitesides, Atlanta, is a featured guest speaker for the 18th Postgraduate Course on Fractures and Other Trauma sponsored by the American College of Surgeons. The meeting is scheduled for May 8-11, 1974 in Chicago, Illinois.

Sixth District

The proposed medical school at Mercer University in Macon was discussed by **Beverly Forester** before the Sandersville Rotary Club in February.

At the February meeting of the Georgia Psychiatric Association **James B. Craig,** superintendent of Central State Hospital in Milledgeville, was named state Man of the Year in Psychiatry.

A framed resolution in praise of 40 years service to the community was presented to **George L. Walker** February 12 by the Griffin City Commissioners. Dr. Walker is in semi-retirement.

Seventh District

V. L. Curry, Austell, along with a Mableton contractor, has been named member of the Cobb County Hospital Authority. Dr. Curry's term will expire in August 1978.

Ninth District

Gainesville physician **James Butts,** board certified in internal medicine, has become certified in oncology. Dr. Butts is a graduate of Emory University School of Medicine and is in practice at the Northeast Georgia Diagnostic Clinic.

Tenth District

Donald C. Abele, Augusta, is one of three authors of "Tinea Faciale: An Often Misdiagnosed Clinical Entity" in the March *Southern Medical Journal.*

Hartwell physician **L. G. Cacchioli** has been named to the Board of Directors of the Hart County Association for the Mentally Retarded.

DEATHS

Harold W. Adams

Atlanta surgeon Harold W. Adams died February 26 at the age of 53.

The Atlanta native was graduated from the Medical College of Georgia and interned at Grady Memorial Hospital. His residency was served at Georgia Baptist Hospital.

Dr. Adams was a fellow of the Southeastern Surgical Congress and the American College of Surgeons. He served on the staffs of Georgia Baptist, DeKalb General and Egleston hospitals.

Survivors include his widow; daughters, Mrs. John R. Darnall of Atlanta and Mrs. J. David Morrison of Covington; sons, H. W. Adams, Jr. of Conyers and Ross W. Adams of Gainesville; mother, Mrs. Charles R. Adams, Sr.; brother, Dr. C. R. Adams, Jr.; and sister, Mrs. Marion M. McClellan, all of Atlanta.

Joseph H. McCormick

Joseph H. McCormick, 54, died February 21 at his home following a brief illness.

Dr. McCormick was born in Monticello, Arkansas. He was a Fellow of American Pathology and served on the staffs of Candler and St. Joseph's hospitals.

Surviving are his widow, Mrs. Thiesen Ray McCormick; daughter, Miss Pamela Lynn McCormick; son, Steven Allen McCormick, of Savannah; mother; two sisters; nieces and nephews.

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The Month in Washington

The American Medical Association has announced the filing of a law suit against the Cost of Living Council to seek an end to all economic controls on medicine.

At a news conference in the AMA-Washington office, the organization disclosed that it is seeking an injunction against the Phase IV regulations on physicians and hospitals. It charged that the rules are "confiscatory, arbitrary and capricious," that they violate the "generally fair and equitable" standard established by Congress and that they violate the fifth amendment of the U.S. Constitution.

Announcement of the legal action was made by Russell B. Roth, M.D., President of the AMA, and James H. Sammons, M.D., Chairman of the AMA Board of Trustees.

Quantity and Quality

In its complaint stating its legal action, the AMA pointed out that the Phase IV regulations represent an "attempt to mold the health care delivery system to comport with the CLC's concepts for health care" and are specifically designed "to curb the quantity and quality of health care services as an integral part of the legislative program to induce Congress to enact national health insurance."

The AMA asked that the court declare these Phase IV regulations invalid and enjoin the Cost of Living Council from enforcing them.

In his statement, Dr. Roth said the AMA was filing in U.S. District Court, District of Columbia, a suit seeking an injunction against the Cost of Living Council. "We are asking the court to declare invalid the Phase Four regulations as applied to physicians and hospitals on the grounds that they are confiscatory, arbitrary, capricious and discriminatory.

"We further believe that they violate the very law on which they are based in that they do not conform to the 'generally fair and equitable' standard written into the law by the Congress.

"Finally, we believe that they violate the most fundamental law of the land—the Constitution of the United States in that they confiscate the property of physicians and hospitals without due process of law, a clear infringement of the fifth amendment.

"Those are the legal tenets on which we are basing our case. We are convinced that they are valid and sound and that they will prevail in the courts.

Mere Legalisms

"But while we proceed on legal grounds, I think it is important to point out that we believe the issues involved are far broader than mere legalisms and that they cast their shadows far beyond the limited scope of Phase IV.

"They are issues of principle and they have pro-

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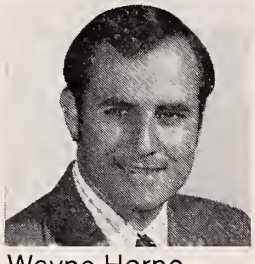
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found implications for the future of health care in this country.

"—It is patently unfair and unreasonable for the services of some working people—namely us physicians—to be subject to severe price controls while permitting other working people to function in a free market. That is not fair play; it is an act of discrimination.

"It is patently unfair to apply a revenue margin limitation to physicians in private practice so that they are penalized if they work longer hours and see more patients. That is not fair play; it is an act of capriciousness—not to mention that it is also short-sighted as hell.

"It is patently unfair when physicians are subject to controls but chiropractors and naturopaths are not . . . when ophthalmologists are subject to controls but optometrists and opticians are not . . . when psychiatrists are subject to controls but clinical psychologists and psychiatric social workers are not. That is not fair play: rather it is an act so arbitrary as to be vindictive.

"Any one of these would be good and sufficient reason to end the controls, in and of itself. For a law that is applied arbitrarily, capriciously and vindictively is a bad law and ought to be abolished.

"But there are even more compelling reasons why the controls should be abolished—not just from health care but from the entire economy.

Controls Don't Work

"Perhaps the best reason for getting rid of them is that they just don't work. . . ."

Dr. Sammons' statement noted that the AMA did not stand alone in its call for an end to all controls. "No less a person than C. Jackson Grayson—chairman of the Price Commission during Phase II—has adopted the same stance," Dr. Sammons said, adding, "he has been echoed by the *Wall Street Journal* and others."

"In the face of this advice and the evidence that controls don't work, why does the Cost of Living Council persist in continuing the controls?

CLC's Many Goals

"CLC officials have made no secret of the fact that they intend to control far more than costs in the health care field through their regulations. The press release from the CLC announcing Phase IV established these goals:

" 'reduce the inflationary rate of increase in the cost of hospital stay;

" 'provide economic incentives for the substitution of less expensive ambulatory care in place of inpatient hospital care where possible;

" 'maximize internal flexibility and incentives for health care managers to improve productivity;

" 'be responsive to cost saving innovations, such as health maintenance organizations and prospective reimbursement plans. . . .' "

"Further, to enforce the last of these goals, the Phase IV regulations were drawn to confer outright favoritism on physicians under contract with an HMO. They have been exempted from the revenue margin limitation that is applied to physicians in private practice.

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"This is not economic stabilization. This is not inflation control.

"This is nothing less than a blatant attempt by the social schemers at CLC to impose their will on the physicians and patients of America.

"What right have they to tell us how to practice medicine?

"What right have they to tell the American people where and how they shall receive their medical care?

"These are *not* economic controls . . . they are political controls. We intend to fight them right down the line. . . .

"We recognize how appealing it is to try—through controls—to keep the lid on at least some costs during this period of astronomical inflation. We certainly recognize and are sensitive to the plight of the great majority of wage earners who have been caught in this terrible squeeze. We have tried to do our share to keep costs down.

"Since the beginning of Phase I in August 1971, physicians' fees have risen but 7.3 per cent while the cost of living generally has risen by 13.3 per cent and legal fees, by contrast, have risen by 26 percent.

"We have cooperated—the figures prove that. But now the time has come to call a halt.

"For the simple truth is that unless the controls are removed—and soon—the quality of health care—particularly in the hospitals—is going to suffer.

". . . And that is precisely what is going to happen very soon if the controls continue.

"We believe the American people had better know and understand that."

Nixon's Health Message

One day after the AMA filed its suit against the Cost of Living Council President Nixon reaffirmed the Administration's intention to keep cost controls on hospitals and physicians until a national health insurance program is approved.

In a second message on health submitted to Congress, the President also emphasized a shift in policy on health education from operating subsidies to direct assistance to students. Nixon said "The nation's total supply of health professionals is becoming sufficient to meet our needs during the next decade. In fact, oversupply in the aggregate could possibly become a problem."

On controlling health costs, the President said "we must avoid the cost inflation which followed the introduction of Medicare and Medicaid. Our health insurance proposal would call for states to oversee the operation of insurance carriers and establish sound procedure for cost control. Until these or other controls are in place, I recommend that our present authorities to control health care costs be continued. I am asking the Congress for such authority." Inflationary pressures are still strong in the medical field, he said, "so that we must maintain federal controls until other measures are adopted under comprehensive health insurance."

Pre-admission Certification

Shortly after the AMA delegation met separately with President Nixon and Health, Education, and Welfare Department Secretary Caspar Weinberger, the latter announced he would drop the hotly contested proposed regulations that would have required pre-admission certification for the hospitalization of Medicare and Medicaid patients.

The President had assured the AMA delegation earlier in the day that serious consideration would be given to changing the controversial pre-admission certification plan.

Those visiting the President were Russell Roth, M.D., AMA President; James Sammons, M.D., Chairman of the AMA Board of Trustees; Malcolm Todd, M.D., AMA President-elect; Ernest B. Howard, M.D., AMA Executive Vice President, and Joseph Miller, Assistant Executive Vice President.

Other topics discussed by the President and the AMA group included the Administration's plan for statewide fee schedules in its national health insurance proposal and area designations for Professional Standards Review Organizations (PSROs).

The AMA delegation told the President of its strong opposition to the pre-admission certification plan as an unwarranted interference with medical and hospital judgments; contended that continuation of fee controls on physicians would be unfair and punitive; declared that fee schedules in a NHI program would be government regimentation; and suggested that the PSRO program needed regrouping and a new start after encountering stiff resistance from physician groups and much controversy and confusion.

Federal Health Budget

The federal government will spend more than $26 billion next fiscal year on civilian health programs if the Administration's proposed budget is approved by Congress.

The budget reflects the Administration's desire to hold health spending in the fiscal year that begins July 1 to about the level Congress approved for the current fiscal year, considerably more than requested. The exception is an unavoidable $3 billion hike in Medicare and Medicaid outlays.

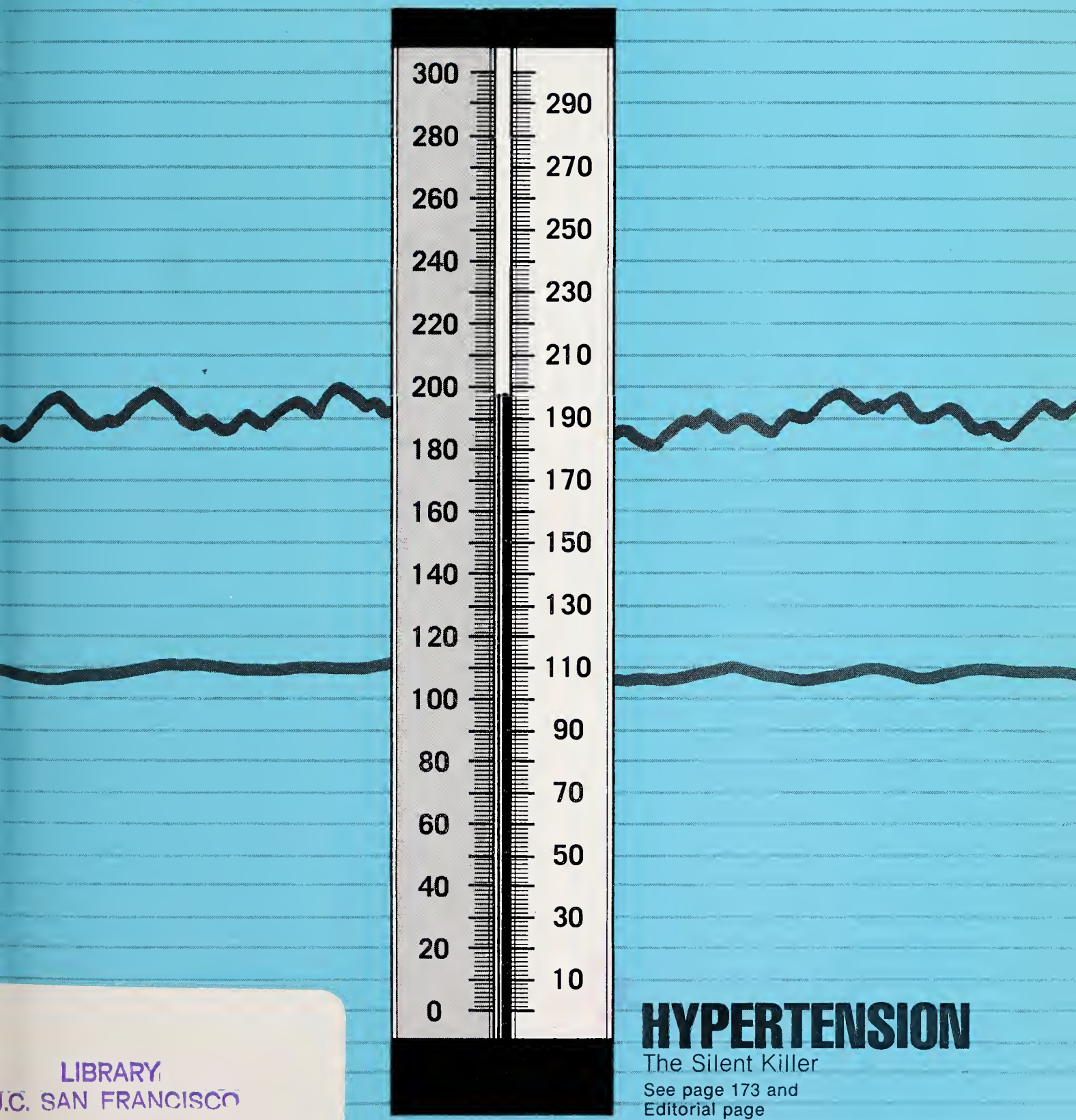
The new health budget is almost $8 billion over the spending in the fiscal year 1973 that ended last June.

HEW Secretary Caspar Weinberger conceded that the budget reflects "in a number of ways the results of that give and take" involved in the battle with Congress last year over HEW appropriations.

No funds are sought for the Administration's new national health insurance program, even if Congress acted this year, Weinberger noted, it would take another year or longer to gear up for the program which carries a $5.8 billion price tag.

The budget emphasized two controversial HEW programs of special interest to the medical profession. To carry out the Health Maintenance Organization (HMO) program, $65 million was recommended for the remainder of this fiscal year, and $65 million for next year. The Professional Standards Review Organization (PSRO) program was put down for $34 million through the remainder of the current fiscal year; $58 million, next year. ■

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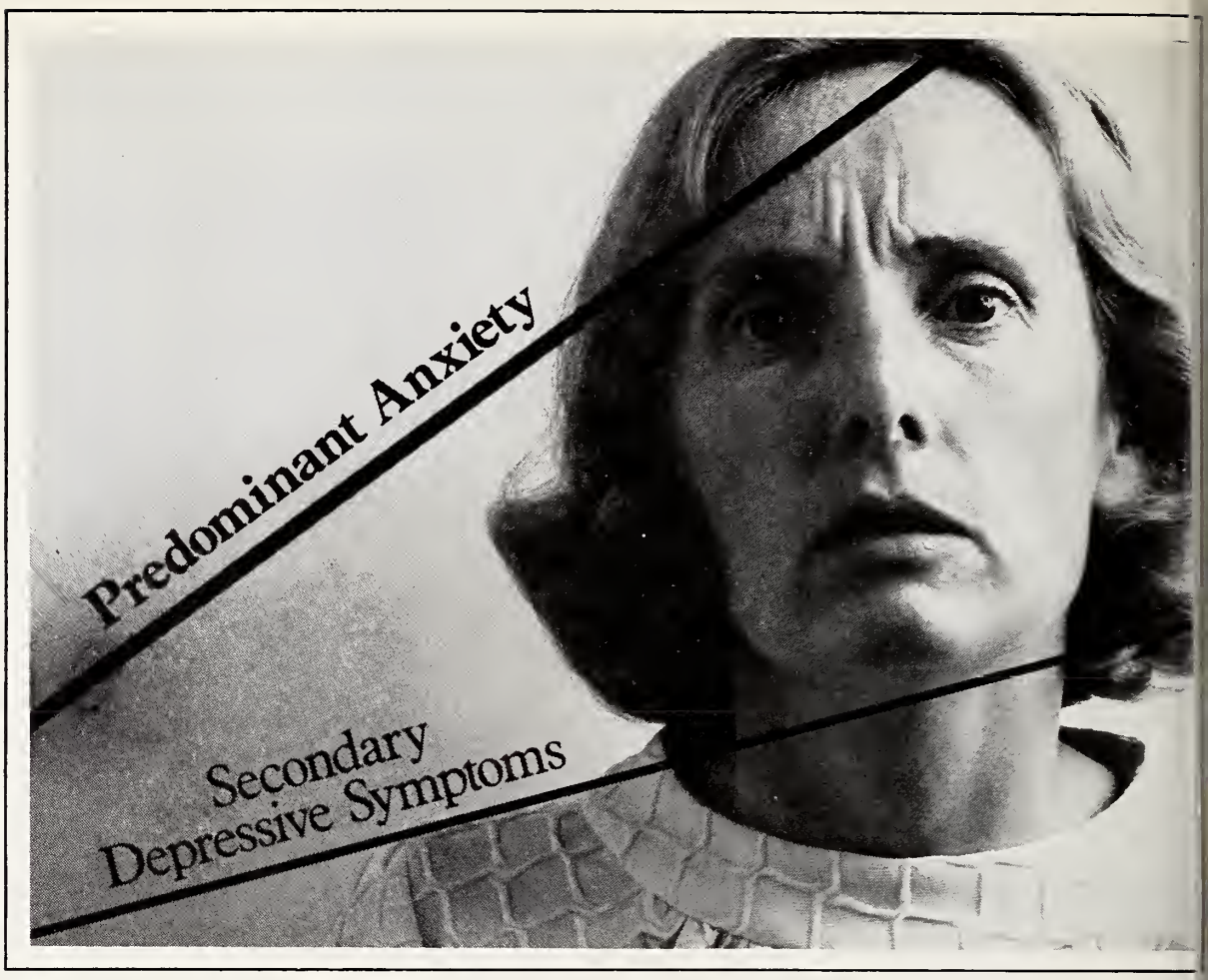


HYPERTENSION

The Silent Killer

See page 173 and
Editorial page

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This psychoneurotic often responds

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

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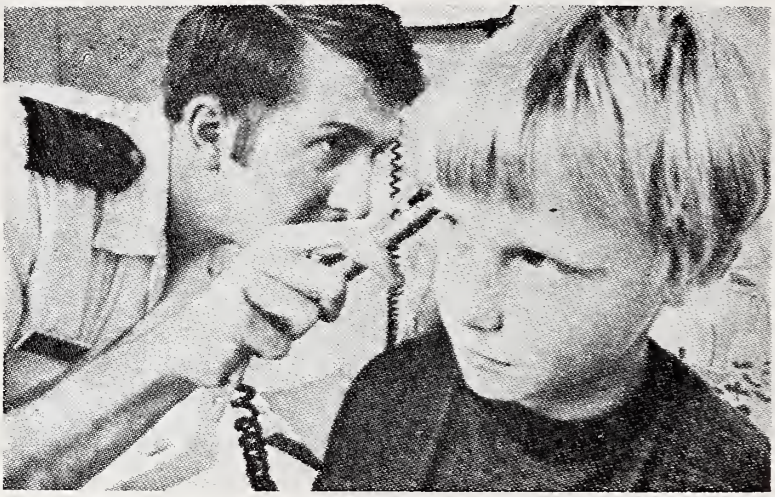
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THE COVER

High blood pressure has emerged as a common, yet little understood disease, that affects 800,000 Georgians.
As May has been designated High Blood Pressure Month in Georgia, this *Journal* is featuring information on the "silent killer" in an article by Albert A. Carr, M.D. of the Medical College of Georgia and on the Editorial Page.



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A report of experience in the treatment of 307 patients over a three-year period in an outpatient hypertension care facility.

Hypertension-Care

ALBERT A. CARR, M.D., *Augusta**

MEDICAL TREATMENT OF HYPERTENSION results in a dramatic decrease in morbidity and mortality due to the disease. More importantly, treatment can reduce the incapaciting events such as cerebrovascular accidents, heart failure, and renal failure during the productive years.[1, 2] Although medical knowledge and adequate antihypertensive drugs are available, the control of hypertension in our population is not adequate.[3] This is probably due to the difficulties in coordinating the political, economic, social and educational factions in this country. The coordination of these factions is an absolute necessity for a successful bid to control hypertension.

Little Adequate Control

Previous population surveys (Baldwin County, Georgia, the National Health Survey and the Alameda County Blood Pressure Survey) have demonstrated certain facts.[4] There were 12,251 people between ages 15-79 years surveyed. Hypertension (blood pressure 160/95 mm of mercury or on treatment for hypertension) was discovered in 18.5 per cent of this population. Roughly half (42 per cent) were aware of their hypertension. Half of those (58.6 per cent) were being treated but only half (48 per cent) were under adequate control. Thus adequate control of blood pressure occurred in only 28 per cent of those with hypertension who were aware of it. Overall, 34 per cent of those with hypertension were treated and 16.3 per cent of the total hypertensive population was adequately controlled.

It is not surprising to discover half of the hypertensive population unaware of the disease since it is in general asymptomatic and requires blood pressure measurements for diagnosis. Even when blood pressure is measured and recorded treatment may not be initiated. This is possible because of certain physician and patient attitudes and knowledge regarding diagnosis and necessity for treating hypertension. Compliance for initiation and continuation of therapy is a cooperative effort involving both the physician and patient. There are a host of economic, social and educational reasons which contribute to success or failure for diagnosis and continued lifelong treatment. Reports which document follow-up in treatment clearly demonstrate a remarkable failure of our system in both private and institutional care. Wilber reports that 41 per cent of patients receiving private care and 55 per cent receiving institutional care failed to return for continued therapy.[4] In addition only 25 per cent initially achieved blood pressure reduction below 160/95 mm of mercury. However, patients who continued under therapy did achieve better control. Of those seeing private physicians 52 per cent were under control. Only 31 per cent remaining in the institutional care system were under control.

This is a report of an on-going experience in an Outpatient Hypertension Care Facility (Hypertension Clinic). The facility is located in the outpatient department in a city-county hospital (University Hospital, Augusta, Georgia). The approach is one of on-going hypertension-care. Cost, availability-convenience, responsibility—patient and physician, and education are stressed in the approach in order to insure continuing care. The ultimate goal is control of hypertension to decrease morbidity and mortality due to the disease.

Study Methods

Some 307 patients with hypertension have been followed an average of 13.6 months; range of 1-36 months. The total experience with this group of patients and the Hypertension Care Facility is three years. The patient population is mostly black (85.6 per cent) and female (63.3 per cent). The average yearly income for 57.2 per cent was and is less than $3,000. Although 62.3 per cent of the patients are the head of their family, only 33 per cent are fully employed. In addition, 50.5 per cent still have children living in their homes. Most (83.5 per cent) get all of their medical care via the outpatient department and the hospital facilities of the University Hospital. The patients live in the immediate geographic area of Augusta. Their age distribution is as follows: 10-19 years—1.7 per cent; 20-39 years

* Professor of medicine and chief of Hypertension and Clinical Pharmacology, Medical College of Georgia, Augusta, Ga. 30902.

—25.5 per cent; 40-59 years—60.8 per cent and 60 or greater years 12.0 per cent. Thus 26.2 per cent of the population are less than 40 years while 72.8 per cent are 40 or greater. This represents a predominately black, female, middle-aged group of patients with hypertension. One hundred patients at random completed questionaires of 79 questions to determine their feelings and understandings in regard to cost, availability, responsibility and education. Data for this report comes from patient records and these questionaires. The physician-director of the hypertension care facility has had direct physician-patient contact with all the patients included in this report.

Costs at a Minimum

The overall emphasis of the care system is to keep costs at a minimum. Expensive diagnostic and follow-up tests are not an essential part of the evaluation. For instance, an intravenous pyelogram is not considered an essential part of the evaluation. The type of initial and follow-up evaluation is variable depending on ability to pay and a judgment as to a financial arrangement with the patient which will insure continuing return for care. This evaluation will be described in section on responsibility.

There are several indirect costs to the patient with hypertension which are not controlled by the physician. According to the patients there are several disadvantages to having hypertension: 36.9 per cent have been refused jobs because of hypertension; 9.9 per cent have been fired from a job because of hypertension; 19.9 per cent find it difficult to get time off from jobs to keep their appointments for treatment. The frequency of return visits obviously can influence cost. The average round trip cost for transportation is $3.89. All patients have to pay for transportation. Lost time from work is an expense; 88.4 per cent have wages deducted because of this time. Also 9.2 per cent have to hire a baby sitter to stay with children at home whereas 10 per cent bring their children with them to avoid this expense. Therefore an attempt is made to keep return visits at a minimum.

Direct costs to the patient are influenced by the type of care. At present there are no physician fees paid by the patient. There is a facility fee of $7.00 per visit. The laboratory, x-ray, cardiogram and medication costs are the additional major items. For 56.2 per cent of the patients there is no direct cost to them; just the indirect costs. The direct costs for these patients are covered by the county hospital authority or Medicaid or Medicare. Medicaid accounts for 30.1 per cent; Medicare alone 5 per cent and with Medicaid 5 per cent. The total on Medicaid and or Medicare is 35.1 per cent. Patients eligible for Medicare have to pay for medications. The total direct cost has to be paid by 43.8 per cent of the patients. The medication accounts for a large part of direct costs. This is reduced for some by antihypertensives donated by pharmaceutical companies. The CIBA Pharmaceutical Company has been particularly generous. An attempt is made to increase the intervals between medication prescription refills. This can be a savings to the patient since there is the cost of filling the prescription (usually $2.00 per prescription) in addition to the medicines. When the intervals between refills can be three months or greater the savings to the patient can be substantial.

Availability of Facilities

The Hypertension Care Facility is located in the outpatient department of the University Hospital in Augusta. The facility is modern and comfortable. There is an extremely large waiting room (93 chairs) with a registration desk. There are 10 examining rooms, a small laboratory for taking blood samples and completing urine examinations and an area for a secretary in the facility. This secretary coordinates and makes appointments and helps keep the records complete and directs patients to appropriate areas in the outpatient department.

The Hypertension Care Facility is available on Wednesday and Thursday mornings. The patients register in the large waiting area where charts are made available 8-8:30 a.m. They are weighed and then taken to individual examining rooms where after 10-15 minutes rest blood pressure and pulse are measured supine, sitting and standing by nurse or an aide. Histories and physical examinations are completed by either nurse-practitioner, physician-assistant, intern or the physician-director of the clinic. Thereafter prescriptions for medications with instructions and appointments for return visits are given to the patient. Laboratory, x-ray and ECG facilities are nearby and convenient when needed. A phone number for contact with the physician-director or his office is made available to the patients with the hope this will help with acute problems between visits and allow for better more orderly entry into the hospital system in case of emergency. Although 97.8 per cent of the patients wanted this number: 36.7 per cent had difficulty getting care between appointments and only 21.5 per cent feel the system is adequate after 5 p.m. and on weekends. The majority of patients feel the morning clinics were convenient; 18 per cent would rather be seen in the afternoon and only 9.7 per cent wanted to have appointments after 7 p.m. The usual waiting time for the patient to see physician is 1.5 hours. Most feel 2.4 hours is not too long yet 21.5 per cent object to the waiting period.

Responsibility—Concern

There is no fixed diagnostic work-up or method for follow-up. Social and economic factors are involved in the choice. The history and physical examination are essential. Urine sediment protein and glucose can be completed in the immediate care area at no direct cost to the patient if a urinalysis charge by the hospital laboratory will increase the cost too much. Otherwise, routine urinalysis is performed by the hospital laboratory. Urine is cultured only when there is history of recent or repeated urinary tract infections. If the patient can afford it a complete blood count (CBC), serum creatinine or blood urea nitrogen, potassium and cholesterol are part of the initial evaluation. However if there is a limitation due to patient finances, a serum creatinine is the test of choice. If finances allow, a cardiogram and chest x-ray are obtained; however, these are not considered essential if there are limited funds and there is no evidence of heart failure, arrhythmias or coronary disease by history or physical examination. Follow-up serum creatinine is considered essential once a year or if there is clinical evidence of dehydration or renal failure. Serum potassium is measured if the patient complains of marked weakness or lethargy.

If symptoms of arthralgia or arthritis develop, the clinical response to Colchicine is evaluated. If there is a beneficial response the serum uric acid is measured. If it is above 10 mg per cent either Probenecid or Allopurinol is prescribed and patient continues on Colchicine. No response to Colchicine requires further evaluation for other causes of arthritis. An initial white count, differential and hematocrit is important since there may be adverse reaction to antihypertensive medications. Correctable forms of hypertension are not found with great frequency in this geographic area. Only if there is initial clinical evidence of renovascular hypertension, pheochromocytoma, mineralocorticoid excess or Cushing's syndrome or failure to respond to antihypertensives are special diagnostic test or hospitalization required. Renovascular hypertension is extremely uncommon in the black population and therefore uncommon in the population described. An abdominal bruit in a patient less than age 50 years with a serum creatinine less than 2 mg per cent requires evaluation including renal arteriography. The hypertensive intravenous pyelogram is not used to screen for renovascular disease because of the great number of false positives and negatives. It is used to look for problems related to recurrent urinary tract infections. Evaluation for mineralocorticoid hypertension is considered if an initial serum potassium is 3.5 mEq/L or less with normal renal function, no acceleration of hypertension and if it is obvious the patient is not taking diuretics. If the serum potassium is less than 3.0 mEq/L on diuretics this diagnosis is considered. Urine tests for pheochromocytoma are performed if history is strongly suggestive.

Evaluation for Cushing's syndrome is performed when history and physical examination are strongly suggestive of this syndrome. In at least two-thirds of patients with pheochromocytoma or Cushing's syndrome the diagnosis is apparent at the time of history and physical examination. Therefore routine laboratory and specific diagnostic test for these diseases are not in order for all patients with hypertension. Patients are hospitalized only when correctable forms of hypertension are suspected or when blood pressure cannot be controlled or when a complication of hypertension such as cerebrovascular accident, hypertensive encephalopathy, extreme renal failure or heart failure occurs and requires more than ambulatory follow-up.

The medical care given is designed so those involved demonstrate responsible care and concern to the patient as an individual. In return the patients are expected to be responsible for prompt return visits and adequate attention to medication doses. Whenever appointments cannot be kept, the patients are expected to call and set up other suitable returns. When this does not happen a letter with a return appointment is sent to the patient. This is repeated twice if appointments are not kept. Thereafter the patient is considered a dropout.

The physician and staff of the Hypertension Care Facility and ancillary services try to impart to the patient a feeling of personal concern. Most (92.3 per cent) of the patients feel the physicians are concerned and 86.2 per cent are satisfied with the time they get with the physician; 96.8 per cent feel the staff at the registration desk is concerned; 79 per cent feel the staff at the x-ray department is concerned and 60.2 per cent feel the staff at the pharmacy is concerned with them as individuals. The majority of patients (89 per cent) feel the staff involved; registration desk, secretaries, nurses, ECG laboratory, pharmacy and x-ray are courteous. Certain attitudes of the patients were evaluated. These attitudes of the patients are important in regard to continued cooperation and treatment. If possible 92.3 per cent want the same individual to see them on return visit and 93.6 per cent would prefer the physician-director. In fact 87.4 per cent feel the physician-director is their personal physician. However, 86.6 per cent feel a physician-assistant and 91.6 per cent a nurse-practitioner gives adequate care to them as long as the physician-director supervises. Only 72.7 per cent feel care by an intern is adequate. The physician-director, nurse-practitioner and physician-assistant are almost always present at all appointments and are the same people. The in-

tern takes part only at one month intervals, and does not have the opportunity of continued contact with the patients. It is of interest that 96.5 per cent of the patients feel the treatment they receive at the Hypertension Care Facility is adequate.

Some patients (60.4 per cent) have seen a private physician in the past. However 90 per cent of these patients feel the Hypertension Care Facility gives adequate care and if they had a choice of private care, 13.2 per cent would want it. However, 40 per cent could get private care and 33 per cent still keep appointments with a physician in private practice yet continue to attend the Hypertension Care Facility. This can be misleading; 82 per cent feel they cannot afford private care and 18.2 per cent cannot get appointments. This plus the fact they feel the care adequate and cheaper at the Hypertension Care Facility may explain why they come to the Hypertension Care Facility.

The patients must feel the Hypertension Care Facility is a place where they can get responsible care with concern for them as individuals, where the availability, convenience and cost must be reasonable. The patients for the most part act in a responsible manner. This is supported by a low drop-out rate of 10.8 per cent. The dropouts are of interest. Several (38.2 per cent) failed to return for known reasons. Either they believed the cost too high or simply did not like the care. This left a group who dropped out for unknown reasons. Thus of the total hypertensive population 8.8 per cent failed to return for care, reasons unknown. There are certain differences in this drop-out group when compared to the overall population.

It is apparent the dropouts are younger and as a group had to pay more for direct costs. There are more males; the female to male ratio is reversed. It seems the young black male who has to pay most of the direct costs for care is more likely to drop out. He may have more difficulty getting time off from work to keep appointments.

There have been 8 deaths or 2.7 per cent mortality over the three year period and two patients have had cerebrovascular accidents. The figures for hypertensive complications of heart failure, left ventricular hypertrophy renal failure and changes in the retinal vessels are not available now. Hypertensive encephalopathy has not been documented.

TABLE I

	Black	Less Than Age 40	Free Care	Female/ Male
Total Population	85 %	26.2%	57.2%	63.3/36.7
Dropouts	92.6%	48.0%	20 %	48.2/51.8

Education

During the initial and return visits, individual efforts are made to talk to the patient about hypertension. No pamphlets or written material is given to them. The importance of keeping return visits and taking medications as prescribed is stressed. The natural history of the disease is discussed with some patients. All (99 per cent) consider hypertension to be a serious disease and 82 per cent consider it more serious or about the same degree of seriousness as diabetes mellitus or heart trouble. It is of interest that 87.6 per cent believe treatment prolongs life and 100 per cent believe their care should be supervised by a physician. Finally 93.4 per cent feel they should not treat themselves. This is of interest since a number of the patients will continually change their medication dose schedule without consulting a physician. Education in regard to taking medications according to instruction, awareness of side effects and diet is an area of weakness in the program. A large number of patients are over-weight and yet attempts at correcting this by diet have uniformly failed.

Summary

This report represents an experience in hypertension—care of a group of 307 patients over a three year period. Hopefully it will be useful to others who wish to set up a care system involving large numbers of patients. There is little or no data on the cost of giving the care to the patient. This will be the subject of a later report. Important in this will be the total cost of care in regard to severe, moderately severe and mild hypertension and the follow-up in terms of complications.

For this particular population the dropout is minimal especially when direct cost to the patient is low. Catastrophic complications are low and mortality over a three year period 2.7 per cent. Females over 40 are more likely to continue follow-up care. There is still a need for better adherence to a prescribed medical regimen. Hopefully patient education and simplification of prescribing methods will remedy this problem. ■

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This study suggests that efficiency and excellence are achieved through effective management and are not primarily cost related.

Quality-Cost Considerations in General Hospitals

BEAUFORT B. LONGEST, JR., PH.D., *Atlanta

IT HAS FREQUENTLY BEEN ARGUED that the quality of care provided in hospitals is a basic determinant of the cost of delivering hospital services. This argument appears logical on the surface. Clearly, extreme situations could exist where severe attempts to curtail costs could reduce quality of care if such curtailment resulted in inadequate staffing or lack of certain necessary equipment and supplies. Of more practical interest, however, is the relationship between quality and costs in hospitals that do not represent extremes—such as in a population of hospitals that are all accredited by the Joint Commission on Accreditation of Hospitals.

In view of concurrent pressure and concern over the dual question of quality of hospital services and the cost of delivering those services, this research was undertaken to determine the relationship between quality of hospital services and the cost of delivering those services in general hospitals.

The hypothesis of this study may be stated as follows: *In general hospitals, the direct costs of delivering services is positively related to the quality of those services.*

This study is concerned with the overall quality of care provided in the study hospitals as well as the costs of delivering those services. Later, four measures of quality that were used in this research will be described. The term "direct costs" in this study is defined as the direct costs of providing services. These costs include salaries and wages of departmental employees, supplies and raw materials. They exclude overhead and depreciation on equipment and plant.

The Population

At the outset of this study, a decision as to what hospitals to include had to be made. The research design could accommodate a large variety of samples or populations of hospitals.

* Assistant professor of Health Administration, Institute of Health Administration, Georgia State University, Atlanta, Ga. 30303.

The term, "hospital," and the even more restrictive term, "general hospital," encompasses an extremely heterogeneous population. That is, the population included varies greatly on a number of important characteristics such as size, regional-geographic location, type of population served, emphasis on education and research and many others. In order to get a population of hospitals as similar to each other as possible on these variables a population of 10 metropolitan Atlanta hospitals was chosen using the following criteria:

1. Community hospitals
2. General hospitals
3. Medium-sized hospitals
4. Accredited by the Joint Committee on Accreditation of Hospitals
5. Non-medical school affiliated hospitals
6. Short-term hospitals

These criteria of selection made it possible:

1. To control for major differences in technology
2. To control for major differences in size
3. To control for major differences in organizational goals and structure

The selection of only 10 hospitals represents a limitation in the research design. Restricting the study to this population means that the results cannot be extrapolated and generalized with total confidence to other community general hospitals on a statistical basis. From a strict statistical standpoint, the obtained findings apply only to the 10 hospitals studied. Theoretically, however, these hospitals may be viewed as constituting a "sample" of the population of hospitals which meet the criteria used to select the 10 hospitals.

The Methodology

In order to test the hypothesis stated above it was necessary to obtain cost measures and quality mea-

sures in each of the 10 study hospitals. Once this was done a correlation analysis using the Spearman rank order technique could be made.

The cost measures will be described first. There are a number of reasons why costs of services in different hospitals or in the same hospital over time are not directly comparable. Among them are:

1. Seventy-five per cent of the costs for a typical general hospital tend to be fixed in nature.
2. Recommended allocation bases can produce varying cost allocations even when the total cost to be allocated is constant.
3. Differences in the *number* of general services provided in a hospital will be reflected as differences in special and routine service costs and total costs.
4. Output measures in use do not reflect changes in the quality of services offered, or differences in the output composition between different hospitals or between two points in time for the same hospital.[1]

Two measures of cost were developed in order to minimize the effects of these restrictions. The first is called the cost-index and is based on a number of key departments for which output, in fairly constant terms, can be measured. The second measure is a man-hour index. Its use is based on the fact that 60-70 per cent of hospital operating costs are personnel costs. Both these indices are derived in basically the same way. They are based on the per unit costs and man-hours of seven departments. These departments are dietary, housekeeping, laundry, medical records, pharmacy, laboratories and x-ray. These seven were chosen because they constitute important cost centers in the hospital and their output can be measured in fairly constant units. Furthermore, these departments represent a broad spectrum of services which contribute to the overall provision of care in a given institution. They can thus, be considered as basic components in a total quality matrix—which is what this study is intended to measure. Nursing has been excluded because there are no adequate output measures available. This is also true for many other services that are related to quality of care.

This represents a limitation of the research but these seven output measures provide a representative picture of the per-unit costs and man-hours involved in providing services in the hospitals. The per-unit cost and man-hour figures were obtained primarily from Hospital Administrative Services (HAS) data or comparable sources. Each hospital was ranked on the per unit costs and per unit man-hours for each of the seven departments. A mean of the ranks was then taken to provide an overall ranking for each hospital on the cost and man-hour indices. Tables I and II contain the rankings and the data upon which they are based.

In selecting measures of quality of care it was necessary to use measures which have been found to be reliable, obtainable without inordinate effort, and broad gauge enough to reflect overall quality and not just some narrow aspect of quality of care. The following measures of quality of care were selected:

(1) Quality of physician education. The work of Lyden[2] and Peterson, et al.[3] verify the usefulness of this measure. The specific measure that was used is

TABLE I

PER UNIT COSTS AND RANK FOR EACH DEPARTMENT IN EACH HOSPITAL.
(Rank is shown in parenthesis)

Hospital	Laundry (per lb.)	Housekeeping (per sq. ft.)	Dietary (per meal)	Pharmacy (per prescription)	Medical Records (per record)	Laboratory (per test)	X-Ray (per exam)	Cost Index: Mean of Ranks for All Depts.
1	.076(2)	.157(4½)	1.580(3)	1.980(8)	9.245(5½)	1.950(6)	9.140(5)	4.86(4½)
2	.125(6)	.110(1)	1.776(5)	2.780(10)	6.390(1)	2.190(9)	7.760(1)	4.71(3)
3	.124(4½)	.214(9)	1.820(6)	1.960(7)	9.245(5½)	2.310(10)	9.720(9)	7.28(10)
4	.170(9)	.140(3)	1.900(8)	2.110(9)	8.776(4)	1.700(3)	8.210(3)	5.57(6)
5	.124(4½)	.136(2)	1.640(4)	1.280(1)	6.500(2)	2.130(8)	9.850(10)	4.50(2)
6	.175(10)	.160(6)	1.388(2)	1.900(5)	9.500(8)	1.890(4)	9.600(6)	5.85(7)
7	.146(7)	.169(7)	1.980(9)	1.880(4)	9.285(7)	1.900(5)	9.640(8)	6.71(8)
8	.080(3)	.191(8)	2.600(10)	1.946(6)	7.530(3)	1.610(2)	8.180(2)	4.86(4½)
9	.169(8)	.275(10)	1.880(7)	1.750(2)	9.550(9)	1.970(7)	9.630(7)	7.14(9)
10	.056(1)	.157(4½)	1.200(1)	1.850(3)	9.950(10)	1.510(1)	8.660(4)	3.50(1)

*Costs are in dollars.

TABLE II

PER UNIT MAN-HOURS AND RANK FOR EACH DEPARTMENT IN EACH HOSPITAL
(Rank is shown in parenthesis)

Hospital	Laundry (per lb.)	Housekeeping (per sq. ft.)	Dietary (per meal)	Pharmacy (per prescription)	Medical Records (per record)	Laboratory (per test)	X-Ray (per exam)	Man-Hour Index: Mean of Ranks for All Depts.
1	.0970(10)	.0634(8)	.3300(4)	.0850(1)	2.5500(6)	.2212(2)	1.600(10)	5.86(5)
2	.0383(8½)	.0190(3)	.3582(5)	.0900(3½)	2.4000(3)	.3600(7)	1.4600(5)	5.00(4)
3	.0383(8½)	.2141(9)	.3680(6)	.0952(8)	2.8159(9)	.4500(9)	1.4259(3)	7.50(10)
4	.0355(7)	.0590(6)	.3888(8)	.0948(7)	2.6000(7)	.4000(8)	1.4000(2)	6.43(8)
5	.0280(3)	.0520(5)	.3184(3)	.0890(2)	1.9650(2)	.3200(5)	1.5600(8½)	4.07(2)
6	.0344(6)	.0600(7)	.3750(7)	.0900(3½)	2.6400(8)	.3000(4)	1.5600(8½)	6.28(7)
7	.0272(2)	.0506(4)	.4702(10)	.0920(5½)	2.8900(10)	.2663(3)	1.5500(7)	5.93(6)
8	.0300(4)	.0147(2)	.3000(2)	.1170(10)	1.9600(1)	.1900(1)	1.2000(1)	3.00(1)
9	.0312(5)	.3148(10)	.3994(9)	.0920(5½)	2.4300(4)	.6170(10)	1.4430(4)	6.80(9)
10	.0234(1)	.0115(1)	.2747(1)	.1149(9)	2.4900(5)	.3355(6)	1.4700(6)	4.14(3)

the percentage of Board certified specialists on the medical staff. Information from each hospital on number of active staff members and number of Board certified specialists was used to compute this measure and rank-order the 10 hospitals on this basis.

(2) The medical staff's self-evaluation. This measure is based upon the response to a questionnaire item as follows:

> On the basis of your experience and information, how does the medical care (including surgical work) given to patients in this hospital compare with other medium-sized general hospitals in the Atlanta area?
>
> ——(1) Top 10 per cent of these hospitals
> ——(2) Is above the average (top 61-89 per cent)
> ——(3) Is about average (middle 40-60 per cent)
> ——(4) Is below average (lower 11-39 per cent)
> ——(5) Bottom 10 per cent of these hospitals

The physicians in each hospital who participated in the study were asked to respond to this question. The questionnaire was sent to members of the medical staff who were members of the Executive Committee of the Medical Staff in each hospital. These physicians were selected because they were in a position to judge the overall quality provided in their hospital. It was also felt that their responsible positions in the hospitals would increase their willingness to participate in a study of this type. There was a response rate of 86 per cent which is quite good. The respondents/potential respondents ratio in each of the 10 hospitals was as follows:

Hospital	*Ratio*
1	12/13
2	15/17
3	8/10
4	13/15
5	10/11
6	9/10
7	6/8
8	10/11
9	8/11
10	10/11
	101/117 = .86

The mean hospital responses to this question were used to rank-order the 10 hospitals in the study on this basis.

(3) Outside expert evaluation. In an attempt to get expert evaluations an unusual opportunity presented itself. There is an official group (for valid reasons we are not at liberty to use their name) in Georgia that has established criteria of quality in the area of appropriateness of treatment and has evaluated the 10 study hospitals (among others) on this basis. They consented to rank-order the 10 study hospitals using their criteria as the basis of quality of care provided.

(4) The severity adjusted death rate index (SADR) of Roemer, et al.[4] They have validated the severity adjusted death rate as a measure of quality of care by showing that it is negatively related to other presumed aspects of quality of care such as the scope of services provided by the hospital and hospital accreditation.

The rankings of each of the 10 hospitals based on these four measures of quality are contained in Ta-

TABLE III

THE 10 HOSPITALS RANK ORDERED FOR EACH OF THE FOUR MEASURES OF QUALITY OF CARE

Hospital	Percentage of Board Certified Specialists on Medical Staff (Rank in Parenthesis)	Hospital Mean Medical Staff Self-Evaluation (Rank in Parenthesis)	Outside Expert Ranking	Severity Adjusted Death Rate Index (Rank in Parenthesis)
1	65.4 (6)	1.55 (4)	6	1.466 (4)
2	88.1 (3)	2.30 (8)	4	1.529 (5)
3	51.2 (8)	2.00 (6)	8	3.578 (10)
4	76.1 (5)	1.10 (2)	5	1.659 (6)
5	85.0 (4)	1.50 (3)	3	0.469 (1)
6	62.0 (7)	2.20 (7)	7	2.506 (8)
7	38.8 (10)	2.40 (9)	9	3.483 (9)
8	90.0 (1)	1.00 (1)	1	0.938 (2)
9	50.3 (9)	2.50 (10)	10	1.719 (7)
10	89.0 (2)	1.90 (5)	2	1.274 (3)

*Rank Number 1 gives the highest quality care. Rank Number 10 gives the lowest quality care.

ble III. To check the validity of these measures a correlation analysis was made. These measures are highly intercorrelated with four correlations being significant at the .01 level and the other two significant at the .05 level.

Data Analysis

To test the hypothesis in this study, Spearman rank order correlations were made using the two cost measures and the four quality measures. Table IV contains the results of this analysis. In interpreting this table remember that the lower the direct costs and man-hours per unit of output, the lower the rankings as shown in Tables I and II. Thus, for the 10 hospitals in this study, the lower the costs and man-hours the higher the quality of care given in the hospitals. Six of the eight correlations are significant at the .01 level. This offers very strong evidence that hospitals which give higher quality of care tend to provide services at lower direct costs and take fewer man-hours to provide them. This means that the ideal objective of the hospital of providing high quality care at the lowest possible cost is not only desirable but pragmatic and consistent. The two go hand in hand and probably result largely from effective management.

Conclusions

The hypothesis: *In general hospitals, the cost of delivering services is positively related to the quality of those services,* is not supported and must be rejected, at least within the constraints outlined for this study.

The main implication for hospitals is the relationship between high quality and efficient operation of the hospital. The evidence here suggests that hospitals which are able to provide services in an efficient manner tend to produce services of higher quality. This suggests that effective management can lead to efficiency and excellence.

TABLE IV

RELATIONSHIPS BETWEEN QUALITY OF CARE AND COSTS AND MAN-HOURS

	Percentage of Board Certified Specialists	M.D. Self-Evaluation	Outside Expert Evaluation	SADR
Cost index	+.827*	+.462	+.851*	+.869*
Man-Hour index	+.782*	+.491	+.842*	+.867*

Spearman rank order correlations.
* Significant at the .01 level.

The reader should be reminded that the costs which have been measured are direct costs. This means that the hospitals with lower direct costs (and in this case, higher quality) do not necessarily charge less for these services. Indirect costs and other considerations enter into the question so that the hospitals may charge more for their services even though their direct costs are relatively lower. The important point for hospital management is that there is not a positive relationship between direct costs of services and the quality of those services—at least not over a range of hospitals that provide a relatively consistent level of quality. ■

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The diagnostic and therapeutic features of acute, life-threatening inflammations of the larynx in the pediatric patient is presented in detail.

Acute Inflammations of the Larynx—A Rational Approach

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CHILDREN DO NOT SUCCUMB to acute inflammations of the larynx if the right treatment is initiated at the appropriate time. The converse, however, is also true. Recent information from 12 patients with acute supraglottic inflammation will be contrasted with older concepts in this study of life-threatening inflammations of the larynx.

Croup is the diagnosis most frequently rendered when a physician encounters a respiratory disease, characterized by difficult breathing, and heralded by a characteristic cough. Croup is not a diagnosis. It is little more than a symptom complex and the diagnosis remains to be made.

Early in this century, diphtheria was the most commonly recognized acute inflammation of the larynx. Later, non-diphtheric infections were categorized. Acute laryngotracheitis was the next isolated entity to be recognized. Recently, these infections have undergone further classification, utilizing the laryngotracheal anatomy. Acute inflammation and/or edema of the supraglottic region is now recognized as being clinically distinctly different from similar subglottic pathology. Rarely, if ever, are acute inflammations of a significant magnitude found to involve the supraglottic and subglottic regions simultaneously. Thus, anatomically, clinically, pathologically, and prognostically, these entities are very different.

Anatomical Features

There are several distinct anatomical features in the younger child as outlined by Ferguson[1] that would tend to increase the severity of an inflammatory process in the laryngotracheal region. The anatomically small subglottic region tolerates minimal swelling poorly because of the relatively great decrease in total breathing surface produced. Also, serious edema is easily induced because of the loose attachment of the epithelium to the underlying connective tissue. The epiglottis is relatively longer, somewhat tubular, and redundant. Its softer consistency with its narrow and relatively unstable base gives it less functional support. Additionally, a more acute angle between the glottis and epiglottis allows the epiglottis to fall more readily into the laryngeal inlet.

Given these anatomical features it is germane to pursue a discussion and correlation of the distinguishing features of acute supraglottic and subglottic inflammations. Supraglottic inflammations are generally stated as occurring between the ages of two and five years. In reality, the incidence is greatest during these years but the inflammations can and do occur much earlier and are seen in adulthood. In adulthood, the symptoms are similar to the pediatric age group. In this series, the peak incidence was between one and a half and three years with an average age of three and a half. The female/male ratio is 2:1. Subglottic inflammations with significant airway distress are generally considered to occur under two years of age. An increased subglottic area in the adult usually precludes inflammatory airway obstruction. However, edema, either allergic or post intubation, can lead to significant airway distress.

Epiglottitis is generally depicted as being abrupt in onset with rapid progressive respiratory obstruction. Seven patients in this series had a prodrome of greater than 24 hours. All were consistent with a mild upper respiratory tract infection. The more acute symptoms in these seven had a duration of less than 24 hours. The remaining five cases were only symptomatic for less than 24 hours and four of these, less than 12 hours prior to admission. A correlation could not be made between age and the duration of symptoms. More significant was the fact that the duration of the symptoms was not an indication as to when medical management alone would

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suffice or whether airway intervention would become necessary.

The former can be contrasted with two very distinct subglottic syndromes. The first occurs primarily in males and typically the symptoms of difficult breathing and of a barking cough begin at night without prior symptomatology. The resolution is usually just as sudden as the onset, taking place within several hours. The second syndrome has a more protracted course. An upper respiratory tract symptom complex progresses over several days to respiratory distress with a characteristic subglottic cough.

In this series of supraglottic inflammations, shortness of breath was the predominant symptom. The child, toxic and ashen, sits erect. Inspiration is significantly prolonged and increased salivation frequent. Six cases presented with a history of drooling as the initial symptom. Several patients exhibited voice change that is best described as a muffled, thick, gutteral voice. In many instances, the child was too toxic to expend energy on vocalization. Hoarseness is a frequent complaint in subglottic inflammations but is not seen with supraglottic pathology.

The signs of exhaustion and temperature elevation usually are more pronounced in supraglottic inflammations. The white count is also generally higher in the former. In all instances in this series the temperature, the pulse, and the respiratory rate were increased. The temperature range was 101 to 104 with an average of 102.6 and the average respiratory rate was 48. The white blood count was also elevated, averaging 18,000 with a range of 10,500 to 29,000. The most significant prognostic signs for supraglottic infections were those of cyanosis and exhaustion. These occurred simultaneously in three cases and in all instances medical management was not sufficient. With the proven efficacy of racemic ephinephrine for subglottic inflammations, cyanosis and exhaustion do not assume the same therapeutic significance.

Techniques for Diagnosis

A definitive diagnosis can be made utilizing one of three techniques—direct visualization, AP and lateral soft tissue x-rays of the neck, and endoscopy. One or more of the above were used to make the diagnosis in all of the cases in this series. When presented with a child with the symptoms and signs of acute supraglottitis, a properly controlled oropharyngeal examination will reveal the characteristic acutely inflamed edematous epiglottis. This method of examination should be performed only once as with each manipulation there is a risk of total obstruction. The patient should be well oxygenated prior to attempting direct visualization.

Lateral and AP soft tissue films can adequately differentiate supraglottic and subglottic pathology. In the lateral projection the marked swelling of the epiglottis is easily seen. In addition, ballooning of the hypopharynx is apparent. Swelling and a decreased subglottic lumen can be visualized on the lateral view as well.

Direct laryngoscopy and/or bronchoscopy should be performed prior to either intubation and/or tracheotomy to confirm the diagnosis and to rule out other potential lesions. In supraglottic inflammations, it will be found that most often the infectious process not only involves the epiglottis but the aryepiglottic folds and in some instances the false cords as well.

Endoscopic examination in subglottic inflammations reveals the lesion to be firm and indurated. In some instances the tissues are coated with a dry exudate. When an allergic diathesis involves either region, a watery edema is found.

Haemophilus influenzae has been implicated in most texts as being the predominant organism in supraglottic infections. Several recent publications have implicated the organism in less than 50 per cent of the cases. In this series it was possible to make a bacterial diagnosis in only six instances. Four of these were H. influenza, and two were diplococci. In the remaining six cases, oral and hypopharyngeal swabs as well as blood cultures were negative. The pharyngeal swabs were positive in only three cases, thus, reinforcing the need for blood cultures if the number of documented infections is to increase. In subglottic inflammatory disease the viral theories are currently the most widely espoused. However, both allergic and bacterial etiologies can and do occur.

Management

For years, the cornerstone of management for acute supraglottic inflammation has been tracheotomy. The complications of tracheotomy, both immediate and delayed, are well known. These complications also are known to increase significantly when an emergency operation is performed by a surgeon infrequently exposed to this type of problem. A more conservative form of management, whenever possible, would, therefore, seem appropriate. It must be emphasized that a conservative approach requires an increased investment of time and energy. At the bedside must be a competent endoscopist with all of the essential equipment. It has been demonstrated in this study that the success of medical management will become quite clear in a two hour period. Our current management protocol for supraglottic infection is as follows: First, medical man-

agement when feasible is given a two hour trial. Should this prove unsuccessful, intubation is effected. Tracheotomy no longer will be performed unless the internal lumen of the tube to be placed is so small that crusting becomes a problem; the patient cannot be extubated in 48-72 hours; or the very rare contingency that the patient could not be intubated. Precedent for intubation as a therapeutic modality has been established. Raj[2] has reported five of 13 supraglottic inflammations successfully intubated essentially without sequelae. Geracci[3] reported two cases successfully intubated for 48 and 54 hours. A prospective trial was reported by Träff[4] in which seven of eight patients had nasotracheal intubation for acute supraglottitis. Six were extubated within 48 hours. One patient was intubated for 83 hours. One adult did not have respiratory distress and was not intubated. With repeated laryngoscopy, ulceration and/or abscess formation were not evident. It is interesting that steroids were not used in this study. Perhaps this explains the prolonged period of intubation necessitated.

In our series, medical management alone sufficed in eight cases. Two cases received a tracheotomy. These were performed prior to the initiation of our current protocol. Two patients were intubated.

Medical management consists of humidification in a steam room. Ampicillin and steroids are started as soon as cultures are taken. Ampicillin is given in a dosage of 200 milligrams per kilogram I.V. for 48 hours. Then the dosage is tapered to 100 milligrams per kilogram and the treatment administered for a total of 10 days.

The initial steroid dosage is established as follows: One milligram per kilogram of Dexamethasone is administered for the first five kilograms. Then one milligram is administered for each additional five kilograms. This is given I.V. The initial dose is repeated in four hours and then every six hours thereafter until extubation is effected. Post extubation this dose is halved and steroids given at six hour intervals for the next 24 hours.

The 12 cases were analyzed with regard to the parameters which might dictate those cases that would not respond to medical management. The initial respiratory rate, pulse rate, and temperature elevation were not indicative. Rather, the potential and direction of change of the aforementioned recorded over a two hour period, was very significant. A significant medical response as manifested by a decreased respiratory rate was seen in four cases in less than one hour and within two hours in the remaining four cases (Table 1). It is of significance that in one of the eight cases steroids were withheld for the first two hours with a significant deterioration in the patient's condition. Steroids were then given and within two hours there was a definite clinical improvement. It should be noted that the steroid response could not be correlated with the length of symptoms prior to admission. Also, those patients whose initial difficulty was primarily dysphagia seemed to have a more benign general course.

TABLE I

STEROID RESPONSE
8 SUCCESSES

	Time	Respiratory Rate
J	30 Min.	45-32
JD	45 Min.	48-26
HR	1 Hr.	52-30
BS	1 Hr.	26-20 (Stopped drooling)
PA	2 Hrs.	40-28
CT	2 Hrs.	40-26
SS	2 Hrs.	48-26
HW	2 Hrs.	26 ..... 40 20
		No steroids / Steroids

Airway Intervention

An analysis of the four cases requiring airway intervention revealed a syndrome of cyanosis, exhaustion, and severe sternal retraction to indicate an initially poor medical response. Three of the cases requiring intervention manifested the triad, whereas one did not exhibit cyanosis. Three were under 22 months of age and one was eight years of age. The first of the four cases, a 20 month old female, had all of the poor prognosticators. Her condition deteriorated within two hours in spite of adequate steroid therapy. A tracheotomy was performed. The postoperative course was complicated by a right upper lobe pneumonia that was felt to be secondary to aspiration.

The second case managed by a tracheotomy was an eight year old female. She did not receive preoperative steroids and did have the poor prognostic triad. One hour after admission, a rapid deterioration of her vital signs necessitated airway intervention. There were no postoperative sequelae. Neither of the cases requiring intubation had preintubation steroids. Both children were taken to the operating room from the Emergency Ward. The 20 month old presented with exhaustion and severe retraction; whereas the 22 month old demonstrated all three poor prognostic indicators. Steroids were administered in the post intubation period and extubation was rapidly effected. In thc first case extubation was within 24 hours and in the second case, within 27 hours. Prior to extubation, laryngoscopy revealed a definite decrease in the induration and in the overall epiglottic size. Following extubation, their airways were never in jeopardy. No ulcerations were noted at laryngoscopy and follow-up revealed no delayed sequelae.

The intubation procedure followed in this series is as follows: Halothane is given by mask prior to intubation. Although in the younger children awake intubation is feasible, a halothane induction is felt to be preferable. Muscle relaxants are contraindicated. Sedatives could be hazardous and are not employed. A tube one size smaller than normal for a given patient is used to compensate for the induration.

The postoperative management of the intubated patient closely parallels that of a tracheotomy patient. A nurse must be in constant attendance and humidification is essential. A steam room or tent suffices. Suction and irrigation of the tubes are performed at 15 minute intervals. Chest physical therapy is instituted. The larynx is carefully observed at 24 hour intervals and the patient extubated as soon as possible. In these cases, muscle relaxants were not necessary during the period of intubation.

Table II correlates the duration of hospital stay with the method of management. The results confirm the fact that an open-minded conservative approach as outlined has merit. However, further investigation is warranted.

The management of subglottic obstruction has been revolutionized in the past 10 years. Racemic epinephrine in a 1:8 dilution is administered by intermittent positive pressure. In conjunction with steroids and antibiotic therapy, the need for tracheotomy in inflammatory subglottic disease has essentially been eliminated. This is true for all cases regardless of the amount of cyanosis, providing the treatment is properly administered. It is interesting that racemic epinephrine does not have a similar affect on supraglottic inflammations.

The dramatic success of the aforementioned therapy should not dull one's diagnostic acumen.

TABLE II
HOSPITAL DURATION

Management	No. Patients	Days
Tracheotomy	2	
Extubated 7 Days		10
Extubated 8 Days		10
Intubation & Medical	2	
Extubated 24 Hrs.		3
Extubated 27 Hrs.		4
Medical	Total 8	
	2	2
	5	3
	1	4

Repeated subglottic inflammations should be circumspect and thorough investigation performed. All patients in both categories should have baseline soft tissue films obtained prior to discharge from the hospital.

Summary

Twelve cases of acute supraglottic inflammation have been analyzed and a conservative method of management suggested. Supraglottic and subglottic syndromes were compared and differentiated. The past 10 years have seen the virtual elimination of the necessity for tracheotomy in the management of acute subglottic inflammation. In the next 10 years as experience increases, hopefully, tracheotomy will prove to be rarely indicated in the management of acute supraglottic inflammation. ■

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A NOTE ABOUT AUTHORS

The *Journal of the Medical Association of Georgia* gladly fills the request of Virginia McNamara, M.D., assistant professor of the Medical College of Georgia, to have the following note published: "In listing the authors of the article, 'Gonorrhoeae: Control Through Culture and Counseling' in the October 1973, Volume 62, Number 10, I failed to include a very important member of the team, Dr. Fares John-Sanchez, Director of Laboratory Medicine at the Medical College of Georgia." Additional authors listed with the article include Armand B. Glassman, M.D., William A. Scoggin, M.D. and Edwin S. Bronstein, M.D.

TUBERCULOSIS PROPHYLAXIS INFORMATION

An excellent source of information for the practicing physician regarding an effective prophylaxis program for prevention of tuberculosis may be found in a pamphlet entitled "Preventive Treatment of Tuberculosis" by Laurence S. Farer, M.D., Assistant Chief, Tuberculosis Branch, Bureau of State Services of the Center for Disease Control in Atlanta. These pamphlets may be obtained by writing the Georgia Lung Association, 1383 Spring Street, Atlanta, Ga. 30309.

PSRO—An Opposing View

J. W. JOHNSON, M.D., *La Jolla, California*

MR. CHAIRMAN, FELLOW SPEAKERS, AMA members and guests . . . I wish to thank the AMA for inviting me to this convention today. I was invited earlier this week which is a rather short time to prepare for a speech, but I appreciate the opportunity anyway. The reason explained to me was that the AMA feels there is sufficient pressure regarding PSROs that an opposing view should be presented on this panel. I think the AMA is not to be blamed for this—when this conference was prepared six or more months ago, I don't know that enough of us knew enough about PSRO's to present an opposing view. . . .

I am going to present, largely, the information that I have been talking about in San Diego, with some revisions. . . . Now, I stand in strong, unequivocal opposition to this legislation. As I study this law and talk with a number of people around the country, I find this law increasingly to be offensive. Someone said this morning that as you study it you like it better. I find just the opposite. My information is based on reading the *AMA News,* which I believe is an excellent paper which all doctors in this country should study weekly as much as they do their medical textbooks. I base it on conversations on the telephone with a number of state society presidents, and I hereby apologize to any of you who may be here for interrupting your offices with my phone calls.

About the Author



J. W. Johnson, M.D., a La Jolla, California general surgeon in private practice, is president-elect of the San Diego County Medical Society and an out-spoken critic of the PSRO law in his area. This address was delivered during the AMA Clinical Convention in Anaheim, California in early December 1973. A similar speech was given at MAG's Rally to Repeal PSRO April 7 in Atlanta.

I base it on some thought in the middle of the night when I was unable to sleep and I think it would be very important for most of you to do just that—sit and think how you would perform in a PSRO. I take the view, regardless of what this law says or how it has been presented here today, that when a government bureaucracy of this size gets going there is no way but what it can get larger as the pyramid of people in it becomes larger and the regulations become more and more complex. I ask you to sit in the middle of the night and think how you yourself would perform in a PSRO. I feel that the seeds of the destruction of civilized, humane medical care have easily appeared in this bill.

A History Book on PSRO

Why do we have PSRO? As I read the history books, and, of course, others will read them differently, I see the AMA in 1970 working on the Medicredit bill, which they presented, I think, not only because they felt like it was a good bill, but because they saw inequitous bills being presented in Washington and wished to have a valid alternative. I understand that they went to Sen. Bennett [Wallace F. Bennett, R-Utah], Congressman Mills [Wilbur Mills, D-Ark.], who suggested a peer review mechanism. They then came back with PRO, which I believe was educational and not punitive. As this went on through the legislative departments up to the Senate Finance Committee, again as I read the history, the PSRO concept developed. I believe then that the AMA was trapped in this situation.

Now, I think that the AMA fought vigorously against this law. If you will study the transcripts of Senate committee hearings, you will see that one of the people testifying against the law used the word "inquisitional." I think, according to several sources, then that AMA fought this vigorously and I do not believe that we should criticize the AMA for their part in this. I know that some people have. I don't believe that's fair as I see it. Unfortunately, 13 state medical societies and an unknown number of medical foundations testified against the AMA position.

Self-Denigrating Attitudes

What are other factors bringing about PSROs? I'll quickly enumerate several as I see them. One is the self-denigrating attitude of a fair share of the

medical profession. I hear it every day. They seem not to listen to people like Professor Ginzberg of Columbia University, who said, "Public dissatisfaction with medicine is not deep or deepening." Again, he said, "I do not see a major crisis looming ahead."

I think, however, if you will listen in your hospital lounges, a majority of doctors will tell you that the public does not like us. Personally I do not believe that. They seem not to have seen the Gallup Poll which was published in the *AMA Newsletter*. You will notice, I am quoting AMA information. I do believe in this. I think all of us should read these things they send us. We find in San Diego one of our problems is that the doctors will not read anything even though it is sent to them several times. They apparently did not read about the Gallup Poll in which respondents were asked to name two of the nation's most important problems. Sixty-two percent mentioned the high cost of living. Fourteen other problems were mentioned—not one of these was medical care. But the doctors persist in their masochistic attitude with too many of them listening to the politicians and our own in-house doom sayers.

Another factor, I think, are such studies as the HASP program. I have to apologize to the people from Illinois because I have to hit this item rather vigorously. Again, there is no point in my coming on this unless I do. HASP (Hospital Admission and Surveillance Program) State of Illinois—I wish they had named the acronym somewhat differently. It's hard to say HASP, perhaps RASP or GASP.

Briefly, in the *JAMA* earlier this year, there was a long, complex, professional-looking article with many diagrams and graphs. The conclusions of all of this were three:

1. They said that by their studies on hospital admissions and controls they had reduced the average length of stay from 7.2 days to 6.2.

2. They said that they reduced payments to hospitals by $9.6 million during the seven-month HASP evaluation period.

3. They said that while there was a 21 per cent increase in Medicaid-eligible recipients, there was only a 1.5 per cent increase in the state payments to hospitals.

I was very worried about this. This was a very excellent looking article. If these facts are true, then I am very hard put to it to fight PSRO. Except, it does not, I think, address itself to the cost of doing this, nor do I think it addresses itself to the possible damage to the doctor-patient relationship if this thing is carried to excess. But I can tell you that I felt that I was very nearly providentially led when about three days ago I picked up the latest issue of *JAMA* and found a superb critique of this HASP article. . . .

This article is well worth your reading; in fact, both of them are very well worth your reading because I see this as essential and critical to this whole PSRO discussion. This article, this critique, was a systematic slaughter in the most polished fashion. The authors, none of which were M.D.'s, categorized three problems with the original thesis.

1. They said that the study failed to account for causal factors other than HASP.

2. There was a weakness in the HASP evaluation time period selection.

3. There was a weakness in measurement criteria.

Very briefly, and I think this is critical to the issue, I will tell you what they mean by that.

1. The critique says that the per diem rates paid to hospitals under the HASP period were less than the per diem rates paid under the pre-HASP period.

2. The time lag in payments to hospitals resulted in inclusion in HASP evaluation period of cost data experienced prior to the HASP period.

3. HASP was not fully implemented in January 1972, but was phased in over six months. Therefore, some portion of cost and utilization data during this period did not occur under the program.

4. The author said that the 7.2 day stay during the pre-HASP period was for Medicaid patients under age 65, but the director of the Illinois Department of Public Aid said that the 7.2 days was for all ages.

5. The Illinois Hospital Association said long-stay cases such as psychiatric, rehabilitation, premature infants were omitted from the HASP evaluation period but included in the base period. And finally, the age and diagnosis categories and length of stay figures were not disclosed. Given the brevity of time periods, if the patient groups differed only slightly in makeup the figures could be markedly biased. All of those last items are by the authors, they are not my interpretation of them.

Now one is forced to conclude after looking at that sort of study, which you must remember is very critical to the isssue of PSROs, that rigid control proponents are either dissembling or have failed the course in statistics. By the way, in this article is something which I resent deeply. I am going to quote it to you so there is no mistake in what is said, "There is far more to quality assurance than merely utilization review and *anecdotal* review by groups of well-meaning physicians reviewing charts."

I couldn't believe that so I looked in my big *Webster's Dictionary* for the definition of "anecdote" thinking there might be a "number 5" definition that I didn't know about. I found however, just what I thought, it is "a short narrative of interesting or amusing incidents." I resent that. I think many of

us are spending endless hours in this type of work and to call this "anecodotal" I believe is totally unfair and helps to promote the trouble that we are in now. Based on this kind of performance and philosophy, one might raise the question raised by the old Roman poet Juvenal, "But who shall guard the guardians themselves?"

Quoting Dr. Heard

Doctor Heard of Georgia [John Heard, immediate past president, DeKalb County Medical Society] wrote the most beautiful editorial in the *AM News* a few weeks ago. I would hope that he would be here, I would like to compliment him. But among the important things he said was that if everybody from Congress and the bureaucrats on down say that most of the doctors are good doctors and are doing a good job, why then do we have to put ourselves in a straightjacket to catch up with a few bad doctors?

By the way there were figures published in this state recently showing that the State Board of Medical Examiners in this state has disciplined, in one way or another, a fair number of doctors. Now we have a large state with a lot of doctors and the percentage is low. But for anyone to say nothing is being done about poor medicine I think is grossly unfair. . . .

A few days ago the California Health Data Corporation published some very interesting figures which should be noted, I think, by everybody. They said that the length of stay of common diagnoses is shortening in the U.S., especially in the West and particularly in California. Thank goodness I'm from California. They mentioned, as an example, displaced intervertebral disk, which I did not realize but which is one of the commonest causes of hospitalization, has been reduced from a half to a whole day during the past five years. This is all over the country depending on what part you want to talk about.

What is PSRO? You've heard it so much, but many people don't know. I came in the door out here this morning and a gentleman was asking a girl, "What is *PSRO*?" And she said, "Well, it's PSRO . . ." and he said, "Well, I don't know anymore than I did." That's the situation all around the country. I go down the hall in my own hospital, many people do not know what this is but it is very interesting when they study it for a while and look at it they come up with the same answer . . . that this law is not a good law. . . .

The law addresses itself to Medicare and MediCal [California's Medicaid program]. The government pays, as you heard earlier, 38 per cent of the medical care in the country. But stop and think behind that . . . why are they paying 38 per cent? Suppose that we would take the food industry and the automobile industry and say that we're going to have the government somehow shelter 38 per cent of these organizations. Then the total charge for that would be enormous and then Congress would get together and put some PSRO controls on them. There is a bit of stretch of logic behind the whole thing in the first place to set up a law which is expensive, and then say it's expensive and then get some more rules to control it.

The law is "skeletal" in nature . . . that was one of the early words that bothered me and here again I think the AMA is responsible for letting us know that. I'll discuss that item in a minute. It calls for computerized norms which you've heard about and I won't dwell on. It calls for fines of up to $5,000 for doctors who in retrospective review by PSRO committees have ordered unnecessary tests or hospitalizations. It calls for local hospitals review but only if the PSRO approves. It can review office records and

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facilities. The only thing required is that the secretary approve it. It can call for prior certification of admissions or costly treatments, and it protects in civil liability if a doctor follows the PSRO norms. . . .

What is wrong with PSROs? Why am I so opposed to them? First of all, I think it is nonsense to conclude that this will cover only Medicare and MediCal. I believe that the big insurance companies are sitting on the sidelines with their big computers hardly able to wait until this thing gets going so they can join.

Cost control is the thrust of this law. We've heard that back and forth today—is it cost control or quality control? All you have to do is read what the law says and draw your own conclusions. I believe it is mainly cost control. True, if we're honest physicians and we become involved with this we should carry out quality control, but I do not believe that is the thrust of the law.

Why do I think this will not work? This will create, as I see it, a gigantic bureaucracy to run this thing. There are articles in the *AM News* recently indicating just the amount of computerized data that will have to be worked with. There will be many secretaries, nurses, physicians assistants, and I don't think that the doctors will any longer enter into this kind of time and work without pay. As you all know, a hospital here in the West recently had a staff who demanded and is now receiving $50 an hour for utilization review work.

It calls for norms. Now, I have discussed norms with Dr. Paul Pickering of La Jolla who is on the

interspecialty group in Chicago who has been working on this very thing. He tells me that it is not uncommon to discuss such a thing as, for example, what would one do with a hernia repair admission? One might have a history and physical examination, laboratory work and so forth. People begin to talk about barium enemas, IVPs. Certainly these are needed in some cases, but not all. If these become PSRO norms how can this do anything but raise the cost of this care? Add that to the expense of running the bureaucracy and I do not see how this can possibly save cost and as I said earlier I believe we will ultimately be blamed for it.

Sen. Long sent some of the men from Louisiana out to see a clinic in a Western state. He said this was an exemplary clinic having a great review system. These men went out to the clinic, went through it carefully and I am told by them that they found that the people were spending $2.45 to save $1.

Finally under this item is a dilemma that the physician is in between PSRO norms and the malpractice threat. One of our best physicians in La Jolla, a conscientious, hard-working man, recently went through a 10-day law suit in court. A family sued him because they said he did not detect congestive heart disease and their father was therefore killed in an automobile accident because of this. This man looked tired and exhausted and beat after that period. He won it but he said to me, "If my chart had not been absolutely, completely full of everything needed I would have lost that case." He said, "I will never again have a chart that does not have everything in it even if it costs more money."

Those in this country who are saying that we are not ordering extra tests and studies to defeat the malpractice threat I think are talking nonsense. I think all of us do it every day.

The dilemma then is terrible. On the one hand we can be fined by PSROs for ordering any tests that are unnecessary. On the other hand, before a jury, if we don't have tests that we think might be necessary or even possibly necessary we can lose our case in court.

Now as to the skeletal aspect of this law. This is a short amendment in this big, fat H.R. 1 Bill. But for an astonishing total of 15 items in the 16-page bill a broad phrase outlines a principle and then there is subjoined the phrase, "according to regulations by the Secretary of HEW." And that is exactly what we mean by skeletal. It is true that these regulations must be published in the *Federal Register* for 30 days, but it is a well-known fact that bureaucrats may completely ignore even strong opposition to these. One need only think of the tax laws to know what whimsical, capricious regulations are forwarded. Certainly one could fight these in court, but who of us in the medical profession has the time or money to fight regulations in the courts?

Now computerized norms—of course, you've heard all about that. I might just add one little note. Dr. Shambaugh of Chicago wrote a beautiful letter to the editor the other day in the *JAMA*. He asked how could a PSRO allow people like Jenner, Pasteur and Semmelweiss to get their ideas across. At the time those people developed their ideas they were rejected by the medical profession. He cites a more recent situation in which Dr. Lampert's one-stage fenestration operation was proposed and rejected originally by both academic and private practitioners.

Now we come to local utilization review and here is another stickler. You've heard today, and it is in the law, that, and I believe the AMA may be responsible for this improvement in the law, it says that only if a utilization review committee in a hospital is doing a good job, can a PSRO go along with it. But I ask you to think about that. If I sit down in my utilization review committee room, and I go out and hang up a sign over the door that says PSRO, am I a different doctor who has suddenly become more honest, more intelligent, more able to make good decisions? If not, then I suppose that I will be replaced by doctors from across town from another hospital and I will go across to their hospital and we will each do our thing in a different hospital. I do not believe that make sense.

Where will these teams come from to review us since we have not been able to do it? Will they be sent out from Washington? There aren't enough doctors in the country now, we're told. How can we spend all this time and money in this reviewing which we are said to not be doing now.

Now in the law is said, or people are saying, that we have local control. I think that's partly fictitious. It has been pretty well kept quiet but the state PSRO councils are partly lay people. There is an 11-man advisory board to that state council and it's reported in a recent magazine article that Ralph Nader is already scrambling to get his people on these. Why, if this is local physician control, do we have such an overhead of bureaucracies? State councils, national council. . . .

How do we review offices? Everybody belittles that—it is in the law that office practices can be reviewed. How would we do this, where would the manpower come from? We need the doctors to be working, taking care of people, not going around to other doctors' offices checking their work and perhaps calling patients in to re-check examinations. It sounds to me like nonsense. And yet we talk about it as though it's something practical.

Prior certification—we've been involved in that, some here in California in Medicaid, but that's only

a small number of people. What would we do if we had to get prior certification for admission for all patients and for costly treatments? It would take a bank of doctors or nurses or secretaries downtown to answer these phone calls.

How can people sitting downtown authorize an admission anyway? It is very difficult sometimes for us to decide what is best about hospitalization or not, and we are always conscious of the malpractice threat if we do not hospitalize somebody. Tell me for example, how we would treat a gastric ulcer? Would I call downtown and ask whether or not the patient could be admitted with a proven gastric ulcer? Would some clerk ask me if we tried a conservative treatment with Maalox? Would they then allow me to admit the patient and if the PSRO committee had more surgeons on it than internists would they probably decide that we should treat the patient surgically? If there were more endoscopists or internists would we think that we ought to repeatedly endoscope the patient and treat them conservatively?

This sounds a bit facetious, but I think if you think about it these are problems that we are talking about.

Now the law says that we are protected from civil liability if we follow norms, and I'd like to quote Harry Peterson, because it's public knowledge, head of the AMA legislative department, who says that this is not necessarily so. . . . Note also the liability if you do not, for some reason, follow PSRO norms.

All of these factors seem to me to overwhelmingly condemn this law. It seems to me that it requires a sophomoric view of big government to think that this sort of thing can actually improve quality or reduce costs. I'm taking the liberty now of quoting a prominent person but I think it's public knowledge, in fact it's in the October 28 issue of the *New York Times*. It's by Dr. Charles Edwards, undersecretary for health, HEW, "We're moving into a totally unchartered area. Neither the Congress nor I know where we're going or what we can achieve. We'd like to upgrade the level of health care in this country, but the question is, how do you do that?"

I think that is an excellent statement about this matter. I think we are a long way from knowing how this can be done.

Come, Telegram, Call

People ask me why am I fighting this now, It's been law for some time. I simply say, and I guess this is my only criticism of AMA and I hope it's taken in the right vein of thought, and that is somehow I think this was missed. I myself have gone with my legislative committee to Sacramento and I think that CMA has done a remarkable job in Sacramento helping to pass laws, helping to avoid passage of laws. It's truly remarkable when you know what they've done. I think AMA has done a number of great things. But I've had phone calls from my county society asking me to phone and telegram Sacramento but I don't remember once getting an emergency all out call from the AMA to come to Washington, telegram, call, do everything you can to help us beat this bad law. I think probably if I knew the facts it would be that the AMA people who were working in Washington felt perhaps like

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they had this thing defeated and they didn't see the need to stir all of us up this way. And I especially do not want to be unfair to anybody because I do not know all the facts in that regard. I would only suggest that if any such thing arises again, perhaps an all out, four alarm fire signal might be sounded.

Now, my position is very simple. I am asking for repeal of this law. That may be a simplistic approach but I somehow feel it's possible. They've given us a lot of breaks. I don't understand who in Washington allowed us this two-year interval before this thing takes effect. I have a feeling that the people on the staff of the Senate Finance Committee really, if they had thought that out completely, would have been able to avoid all this trouble we are giving them now by maybe making the thing immediately mandatory. Again, I'm being slightly facetious, but we do have a two-year time period before we absolutely have to have PSRO going or the Secretary of HEW can form his own PSRO for us.

I think that court action to defeat this is probably too slow and the outcome uncertain. I think it is not wise to talk about amending the law. I think the AMA worked very hard to try to get this law to come out right. Furthermore, what is there to amend? This is a skeletal law, we don't know what it is even. In fact, it's very hard to debate the law because we don't know what the regulations are that can make or break this law.

I think it's unwise to sit and talk regulations with the Department of HEW. A physician in San Diego who came over from England told us the other night that when he was in England at the time the doctors were fighting with the government over national health service. He said the critical mistake that they made was to sit down and talk with the government. This implies, I think, that we're already to go, how do we do it?

I think it's not idle to talk about repeal. Now many people do not even know that Congressman

[John] Rarick from Louisiana has introduced H.R. 9375, a bill to do just that. Interestingly enough, we're not talking about repealing H.R. 1, which is a big thick book. We're talking about taking 16 pages out of that bill. Now that all of us are beginning to see that it is a bad bill, I think it might be politically practical. I'll discuss in a minute how I think we might do that.

People say, "Well, you didn't defeat Medicare, how do you expect to defeat this bill?" A totally different thing. Medicare was a package of goodies for everybody. It's an insurance law to give medical care. It doesn't have the seeds of danger that this PSRO law has, though again the AMA said it was going to be dangerously expensive and it was.

Now Alan Nelson, Dr. Alan Nelson of Utah, was quoted the other day in *Medical World News* as saying that Sen. Bennett himself might be willing to withdraw this law if the flack from doctors increases, those are his words. Now, interestingly enough he followed that up by saying that he didn't like the idea because he thought something worse could happen. Many people have said that to me, "If we repeal this law, then something worse will happen to us." I've tried my best to think what is worse, and I don't find what is worse.

"Many people have said to me, 'If we repeal this law, then something worse will happen to us.' I've tried my best to think what is worse, and I don't find what is worse."

One of our young surgeons in La Jolla spent a year in the British medical system. After I had talked with him some about the PSRO law he looked at me one day in rather wide-eyed amazement and said, "Gosh, even the British system doesn't have any kind of PSRO strictures in it."

Now, why do I think it's possibly practical to repeal this law? I'm going to quote now people who I feel have come out against this law, and I have to be very careful because if you read the *AM News* there are oftentimes ambivalent positions taken. I have called a number of state society presidents, as I said I believe these to be facts. And as I say, I'm trying to be very honest about this because there is no point in trying to drum up opposition to this bill if we have to do it on any kind of fictitious, false basis. But the following states, as near as I can honestly determine it, have either said that we want to repeal this law outright, or have said, we'd like to repeal it, we may go ahead and kind of work on it or watch it or set up a temporary PSRO, but that in effect these people have also said they'd like to see the bill repealed: Virginia, Indiana, Kentucky, Michigan, Louisiana, Nebraska, Oklahoma and Texas.

Additional organizations have taken a stand against it. I could hardly contain myself when I noted that Dr. Wonderlick of the LA County Medical Society, which incidently is 10,000 members strong, more than several of our state medical societies, took a strong position the other day against PSRO's. My own San Diego County Medical Society, after extensive debating, went about this in an interesting way, I think. The anti-PSRO people demanded on the ballot, our annual ballot, the question, "Do you wish the society to work for repeal?" The pro-PSRO proponents said in a second question, "Acknowledging that PSRO is a law, do you wish the Medical Society to set up a PSRO?"

The figures were, and we were lucky, we got about a 50 per cent return of ballots which I understand is very good for a return. The vote to seek repeal was something like 714 to 134. Hardly any doubt about how the membership stands. We did prepare them somewhat with extensive debating and hospital staff meetings and harassment. The other question, which as you can imagine would not come on quite as strongly, the Society voted against even setting up a temporary prototype or doing anything at all by something like 530 to 330. I argued about that, that there is no point in talking to Congress about repeal of this law while we're busy in our states and counties setting them up. I believe people will misinterpret that.

Another organization against them is the Orange County Medical Society in Florida. Their wording as reported in the news was that they voted non-participation.

Two or three things that I have here that are fairly recent. I can prove them but they are not in print yet. The president-elect of the California Society of Internal Medicine, who is a colleague of mine in La Jolla, came back from his executive committee meeting the other day and said that his executive committee has voted to recommend to their members repeal. It's not that simple. They also want to see some other things going on but they would like to see the law repealed.

The American Society of Anesthesiologists at their recent annual meeting—I believe about 6,000 members, one of their delegates is a colleague of mine in La Jolla—their House of Delegates in the final day voted to instruct their officers to go to AMA and ask for repeal. That is not in print yet, but I believe it will be shortly.

And a very interesting thing has taken place in Tennessee and I would love to know how the doctors did this. The state legislature in Tennessee sent

a resolution to Washington to the United States Congress asking them to denounce and repeal the PSRO law. Marvelous.

I hope that other states will join these. Maybe there are more that I haven't mentioned and I apologize because I haven't had the time or the telephone money to get all around the 50 states. But I hope there are others that will join us. And then my practical approach is very simple—if the Louisiana people can get their congressman, John Rarick, to submit a bill to Congress, why can not the California Medical Association, all of us go to our legislators who met in Washington and present this to them in a logical manner and ask them to please repeal this law.

Now also, it becomes important for our own AMA delegates to take some action. I have a strong bit of sympathy for Dr. Hunter and the other men on the trustees. In case you don't know, I'm sure most of you do, they cannot take stands, as I understand it, contrary to the delegates and the last House of Delegates didn't tell them to take an anti-PSRO stand. But that was some time ago. We're about to have another meeting. I would hope that the delegates would ask the Board of Trustees to back Congressman Rarick's bill to repeal. I think it's a specious argument to say that we are law-abiding citizens, we must dutifully obey this law when it is equally possible to say we are law-abiding citizens who are going to work very hard to repeal this law.

I end my discussion with a quotation from Thomas Jefferson. He said, "The suppression of unnecessary offices, of useless establishments and expenses enabled us to discontinue our internal taxes. These, covering our land with officers, and opening our doors to their intrusions had already begun that process of domiciliary vexation which once entered is scarcely to be restrained from reaching successively every article of produce and property." And I hope he would allow me to add, "and medical services."

Thank you. ■





Rally to Repeal PSRO

"It can be done" was the theme of MAG's April 7 Rally to Repeal PSRO in Atlanta, a theme echoed by speakers James H. Stewart, M.D. (above left), president of the Louisiana State Medical Society; and (L-R) Rep. Philip Crane (R-Ill.); Marvin Edwards, past editor of Private Practice; and J. W. Johnson, M.D., president-elect of the San Diego County Medical Society in California.

Dr. Stewart reviewed efforts to repeal PSRO in his own state and termed the campaign "but a small battle in a larger war" of working against government control of the free enterprise system. Rep. Crane called for the medical profession to be more aggressive in leading the repeal effort and Mr. Edwards warned against taking the attitude that "The government is going to do it to us anyway, so let's get in and do it to ourselves." He said, "In my opinion, it's government that needs more review, not the medical profession."

Dr. Johnson attacked the law on many sides, calling it "skeletal" and "inquisitional" and predicted it would limit innovative medicine while increasing the cost of medical care. An additional speaker, M. Stanton Evans, senior editor of the Indianapolis News, said he does not believe that a health care crisis exists in the United States today. Noting that the PSRO law came into being because spending for Medicare and Medicaid "it totally out of control," he said the problem the law addresses is one created by the federal government and its intervention into the medical care system."

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Stalking a Misunderstood Disease

THE "SILENT KILLER," high blood pressure, will be stalked relentlessly during May as a nationwide campaign gets underway to educate the public of its dangers. Locally, the Georgia Heart Association is serving as coordinating agency to see that the message of awareness of this misunderstood disease is carried to the public. Governor Jimmy Carter has signed a proclamation declaring May as National High Blood Pressure Month in Georgia and kicked off the campaign by having his own blood pressure checked by Charles Hatcher, Jr., M.D., president of the GHA. Joseph A. Wilber, M.D., is chairman of the task force on hypertension of GHA.

The Medical Association of Georgia is one of many cooperating organizations and agencies telling the story that 26 million Americans have high blood pressure, and Georgia has an unusually high rate of 800,000 afflicted persons. Many of these victims are women, as the disease affects them at a rate 44 per cent higher than men. The black population has substantially higher prevalence rate than the white.

As physicians you can work to see that your patients and the public in your community are aware of the following points this campaign hopes to emphasize:

1. High blood pressure is a contributing cause of stroke, heart failure and kidney failure;
2. HBP is usually asymptomatic and is seldom recognized because it causes no discomfort;
3. The disease can be controlled but not cured—it is a lifetime problem;
4. Daily medication is the most effective treatment, no short-term effort will do the job; and
5. Those who have been told they have HBP should be checked regularly regardless of how well they feel.

Be aware that half of those who have high blood pressure do not know it, half of those who know it are not under treatment, and half of those under treatment do not keep it under control!

How Angry Are You?

THE AFL-CIO IS APPROACHING the 1974 congressional elections with a measure of determination and a degree of expertise believed unprecedented in the history of organized labor. A COPE spokesman notes that "this year, there's more anger." He acknowledges that the AFL-CIO leadership is "extraordinarily aroused."

Now for the big question, how determined are doctors? They have the same motivation as COPE—"there's more anger," but do we let this go off in unharnessed steam by shouting about HEW? Or will we attack the problem as

we do a difficult health problem, with a well organized plan?

How angry are you?

Political organizers working for the Republican and Democratic parties are using words such as "dazzling" and "overwhelming" in discussing the amount of money and manpower the labor movement is expected to commit to the upcoming campaigns.

The AFL-CIO's 1974 campaign efforts are being focused almost entirely on a campaign to elect a "veto-proof Congress" which can muster the necessary two-thirds vote in the House and Senate to override whatever vetoes the President attempts to exercise in his last two years in office.

Three Important Developments

Those familiar with COPE's operations cite three important developments that are expected to give organized labor political influence unmatched in prior campaign years:

First, COPE already has passed the midway point in an ambitious new program to place on computer tapes the name, address, telephone number, party affiliation for every one of the nation's approximately 18 million men and women affiliated with AFL-CIO unions.

Second, the AFL-CIO is planning to establish a new organizing department to coordinate and strengthen control over its field operations—including COPE —under the direction of W. J. Usery Jr., a highly respected mediator and former Labor Department official.

And third, several of the large unions which suspended their affiliation with COPE, when the AFL-CIO refused to endorse the 1972 Democratic presidential candidate, have now returned to the fold.

In 1970, organized labor contributed more than $1.7 million to senatorial candidates, including $100,000 or more to six Democrats. Gubernatorial candidates received a total of more than $1 million, including donations of more than $200,000 to two Democrats, and contributions in excess of $100,000 to two others. In House races, labor contributions amounted to $1.5 million. All this money came from member contributions.

Standing Firm Politically

With the Federal Government encroaching more into our private practice, we need to stand firm politically. The AMA stood firm against pre-certification and indiscriminate price controls with some results. We can be effective when we try.

A medical education is wonderful training for teaching us how to evaluate problems and work out a good result. We tell our patients that good medical care costs money and expect them to shell out, and we also tell them the best treatment is usually the most economical. But 12 years after AMPAC was formed, we are still trying to get doctors to shell out $25.00 for GaMPAC dues. You get the same old excuses—I'll think about it; I'll call you.

Let's back our GaMPAC organization, not with the minimum $25, but with a check for a $100 sustainer membership.

How angry are you? Are you $100 mad?

John P. Heard, M.D.
231 E. Ponce de Leon Ave.
Decatur, Georgia 30030

president's letter

Can Organized Medicine Light the Way?



This is the first of the President's Letters that I will be responsible for during this coming year. I shall try to make them informative and interesting, and also shall try to keep them timely. This latter is more difficult, however, since the deadline for the copy is about two months prior to the time the *Journal* is distributed.

As I write this, the MAG PSRO Rally of April 7, 1974 has just finished. Distinguished speakers and an impressive attendance to hear them were very evident. Harrison Rogers, M.D. gave a fine PSRO update, and summarized what Georgia is doing, indicating that we are a recognized leader in the United States in the effort to repeal PSRO.

Mr. Marvin Edwards, past editor of *Private Practice,* gave a lucid presentation of why PSRO is a bad law. An interesting comment of his was, "We don't want government to do it to us, so we are going to do it to ourselves!"

Mr. M. Stanton Evans, senior editor of the *Indianapolis News,* told us of his concern that the main problem was one of government interference in the total personal life of Americans with other issues secondary to that fact. He cautioned that control inevitably follows subsidy. He also advised us that one should not let one's adversaries determine what the argument is all about, for that determines the issue on which we debate, which is half the battle. The PSRO issue, among others, is based on the contention that there is a health crisis in America, and responding to that argument is admitting the original contention, which may not be true.

J. W. Johnson, M.D., president-elect of the San Diego County Medical Society, presented a historical perspective on "crowd thinking," and hysterical reactions to public feelings. His presentation reminded me of a quote of Seneca who stated that, "Human affairs are not so happily arranged that the best things please the most men. It is the proof of a bad cause when it is applauded by the mob."

Dr. Johnson emphasized that more bureaucrats should look at the other end of the computer: the end that shows the tremendous majority of excellent physicians, and should not concentrate so much on the few that are kicked out by the end of the computer usually surveyed.

James H. Stewart, M.D., president of the Louisiana State Medical Society, gave us a history of Louisiana's involvement since it began opposition to this kind of law in 1970. He noted that medicine is the largest group of individuals remaining which is capable of turning around the massive government interference in our lives and in our economy in America today.

U.S. Congressman Philip Crane (R-Ill.), an outstanding and articulate speaker, gave his usual charismatic address. He commented at some length on the

AMA publications supposedly pointing out the deleterious effects of PSRO, and noted that the title of one of these publications, "Exorcising the Devil from PSRO," should have read "Exorcising PSRO from the Devil." He again emphasized that the AMA's position should be primarily toward repeal, and not toward mitigation of the law by amendment, although stating that the simultaneous working for repeal and cleaning up a bad law were not mutually exclusive. Again he emphasized that under PSRO, the physician is given responsibility but not authority, and is obviously therefore setting himself up as a potential scapegoat.

One of the arguments frequently used by those who do not wish to pursue repeal of this law is to say that there is ample legislation on the books now and in the wings to do what PSRO will do, perhaps even more fearsomely. After hearing the excellent and thoughtful presentations at this Rally, and the encouragement for the burgeoning movement to repeal this wicked law, one might respond to this worry by saying, "Fine! Once we repeal PSRO, bring on the others and we'll repeal them, too!"

A sad commentary on the general mood of the country as it is expressed by such laws as PSRO, Consumer Protection, and other regulation by governmental bureaucracy, is that we are in a state of general distrust of each other. Where did we lose our way? Can organized medicine light our way out of these turbid and troublesome times?



John Rhodes Haverty, M.D.
***President**, Medical Association of Georgia*





ATLANTA-BASED WORKSHOPS DEAL WITH PRACTICE MANAGEMENT, MENTAL HEALTH

Two programs co-sponsored by the American Medical Association came to Atlanta recently for the benefit of Georgia physicians. The first, a practice management workshop March 21 and 22, "Establishing Yourself in Medical Practice," dealt with topics such as interviewing and training personnel, appointment scheduling, collection processes and choosing location of practice. Representatives from Powell, Goldstein, Frazer & Murphy, general counsel to the Medical Association of Georgia, Winston Huff, Randall L. Hughes and Gary D. Zweifel (above left) covered some of the legal problems involved in setting up a new practice. In early April the mental health committees for six southeastern state associations teamed up to present the AMA Southeast Regional Mental Health Conference. Among the speakers was Charles Hollis, M.D. of Albany (above, right), chairman of MAG's PSRO Committee, who addressed the question of PSROs and how they might affect mental health care in the future.

heart page
heart page
heart page

Myocardial Revascularization Current Concepts in the Management of Ischemic Heart Disease (Part II)

ELLIS L. JONES, M.D., SPENCER B. KING, M.D. and
CHARLES R. HATCHER, JR., M.D., *Atlanta**

THE PATIENTS WHICH WOULD PROFIT most from myocardial revascularization are those which have been designated as having the pre-infarction syndrome. The problem lies in defining those patients which will stabilize and those which will proceed to acute myocardial infarction. The answer to this question is at present unknown, but the following groups of angina patients are thought to be most prone to development of myocardial infarction: 1) those with a change in intensity or frequency of previously existing angina, 2) those patients in whom the pain is prolonged and occurs at rest, and 3) patients in whom there are marked S-T segment changes during the episode of angina. The exact frequency with which these symptoms proceed to frank infarction is unknown. The patients at highest risk, however, seem to be those who continue to have angina after being put to bedrest with vigorous medical therapy.

A variant form of coronary insufficiency was described by Prinzmetal and his associates. In this form of angina pectoris, severe episodes of prolonged pain at rest are associated with S-T segment elevation in a specific area of myocardium. Most of these patients have a severe localized obstruction of a specific coronary artery, and can benefit from bypass surgery.

In addition to the anginal pattern, candidates for myocardial revascularization must be selected by cardiac catheterization and coronary arteriography. Surgical candidates are those with significant lesions (greater than 75 per cent) with arteriographically demonstrable suitable distal vessels for bypass and satisfactory left ventricular function.

Critically Placed Anatomic Lesions

Certain patients have strategically placed severe lesions which when associated with angina pectoris are thought to be life threatening. It is in this group that coronary revascularization is performed without the usual attempt at prolonged medical treatment. These are the patients with significant occlusion of the left main coronary artery and those with high grade lesions involving all three vessels. The lethal natural history of this disease has been shown with a two year mortality of 50 per cent in patients with left main coronary artery disease. Although the surgical risk is increased, the most graftifying results are obtained in this severely diseased group of patients.

Contraindications

In general, age per se has not been a contraindication to myocardial revascular-

* From the Divisions of Cardiology and Thoracic and Cardiovascular Surgery, Emory University School of Medicine, Atlanta, Ga. 30322. Part I was published in the April *JMAG*. Prepared at the request of the Committee on Physician Education of the Georgia Heart Association.

ization although some have considered age 70 to be upper limits of acceptability. Severe associated systemic disease is a contraindication. Absolute contraindications would be arteriographically proven inadequate distal vessels and extremely poor left ventricular function.

Severe Left Ventricular Dysfunction

Early in the experience of myocardial revascularization, it was hoped that by improving myocardial perfusion, symptoms of congestive heart failure secondary to severe left ventricular dysfunction might be alleviated. However, high mortality rates, both immediate and within the first year after operation (67 per cent), have tended to reinforce the impression that left ventricular dysfunction, secondary to ischemic heart disease is more often related to replacement of muscle with scar rather than the presence of viable but ischemic myocardium. Patients with angina and transient episodes of congestive heart failure associated with focal areas of left ventricular dysfunction by angiography continue to be candidates for myocardial revascularization. However, coronary artery bypass for symptoms of congestive heart failure unassociated with angina is not performed at the present time.

In proper selected cases, we feel that myocardial revascularization, using either autogenous saphenous vein or the internal mammary artery graft, is an effective means of alleviating disabling angina pectoris. It is reasonable to expect that increasing experience with the operation, will prove that it also has a beneficial effect on patient longevity. ■

STATE SEEKS TO ALLEVIATE MEDICAID NON-AVAILABILITY OF DRUGS

Recent price changes published by Medicaid have prompted Richard M. Harden, Commissioner of the Georgia Department of Human Resources to write state pharmacists of a plan to insure that drugs commonly used for these patients will still be available to them.

The memorandum explains how these drugs, in most instances the choice of the state's physicians for the treatment of common illnesses, had become non-available to Medicaid recipients:

"This situation has come about as a result of the Average Wholesale Price of these drugs being greater than the newly established reimbursement rate under Medicaid. Consequently many pharmacies furnishing such drugs to a Medicaid recipient would be doing so at a financial loss.

"In view of the above, I have this date (April 2) commenced processing a State Medicaid Plan Amendment which will provide for Medicaid reimbursement for the attached list of drugs at actual acquisition cost, plus a dispensing fee. I appreciate this matter being brought to my attention, and further appreciate the opportunity to demonstrate that State Government can be responsive on a timely basis to the legitimate complaints of our Medicaid providers.

"Notwithstanding the current method of pricing, the following drugs shall be paid at actual acquisition cost plus dispensing fee:

Ethaverine HCl
Pentaerythritol Tetranitrate and combinations with Pb
Hydrochlorothiazide
Conjugated Estrogenic Substances
APC with Codeine
Diphenylhydantoin and combinations with Pb
Chlorpromazine
Dicyclomine HCl and combinations with Pb
Piperazine
Propantheline Bromide and combinations with Pb
Promethazine HCl and combinations
Methanamine Mandelate
Nitrofurantoin
Rauwolfia Serpentina
Secobarbital Sodium
Chlorpheniramine Maleate
Diphenhydramine, Ammonium Chloride, Sodium Citrate, Chloroform, Menthol, Alcohol."

MAG SUITE FOR AMA CONVENTION

As we have done in the past, MAG will again have a suite available during the upcoming AMA Convention at the Palmer House in Chicago, June 23-26. The room will serve as a meeting place for the MAG delegation, as well as for other members in attendance.

Come and enjoy the hospitality of the Georgia delegation and consider the MAG suite your headquarters while attending the convention. When arriving in Chicago, call the Palmer House and ask for J. Rhodes Haverty, M.D. or Jim Moffett for the exact location of the suite.

New Physician Disciplinary Law

J. WINSTON HUFF, *Atlanta**

AT THE RECENTLY ENDED 1974 Session, the General Assembly of Georgia enacted important amendments to the Medical Practice Act relating to the disciplining of physicians. These amendments were proposed by the Composite State Board of Medical Examiners after consultation with The Medical Association of Georgia. All physicians should become familiar with the grounds upon which discipline may be based, the manner in which discipline may be administered by the Board and the procedural safeguards in the event of a disciplinary investigation.

Power of Board to Investigate: The new law gives the Board broader and more specific powers to investigate complaints against physicians. Upon recommendation by and concurrence of the Board, the Secretary of State is authorized to hire investigators, including the temporary employment of private physicians for this task.

Grounds for Discipline: The Board now has authority to deny a license or to discipline a licensed physician if the Board finds that the person involved has:

- Failed satisfactorily to demonstrate the qualifications to practice medicine to the Board;
- Knowingly committed fraud in practicing medicine or in obtaining or renewing a license;
- Been convicted of, pleaded guilty to, or pleaded nolo contendere to a crime that is a felony in Georgia;
- Committed any crime of moral turpitude except income tax evasion;
- Had a license to practice revoked or denied, or been disciplined by, any licensing authority;
- Advertised for patients; represented that a manifestly incurable disease can be cured, or lied or exaggerated about his professional ability;
- Professionally conducted himself in a manner harmful to the public, including failing to adhere to the minimum standards of acceptable and prevailing medical practice;
- Been involved in a criminal abortion;
- Knowingly kept a professional connection with anyone violating the medical laws or Board rules; helped anyone practice medicine without a license; split fees for patient referral; engaged in the practice of medicine as an employee of a corporation which is not a professional corporation, except as an employee of a licensed hospital or teaching institution;
- Knowingly violated any law or rule which regulates the practice of medicine;
- Done anything indicating bad moral character or untrustworthiness;
- Been adjudged mentally incompetent by a court of competent jurisdiction, which finding automatically suspends a license unless and until the Board should find the physician to be competent;
- Been unable to practice medicine with skill and safety because of alcoholism,

* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, Atlanta, Ga. 30303.

drug usage or disease. To determine whether a physician has become so disabled, the Board has the authority (i) to order him to submit to a mental or physical examination, and (ii) to obtain and examine all medical records relating to his mental or physical condition, including psychiatric records. However, any such evidence which the physician could withhold from disclosure in a court of law because it is a "privileged communication" shall be heard by the Board in private and may not be used against the physician in any other type of proceeding.

Methods of Disciplining: If a physician is found by the Board to have committed any of the above listed offences it may take any of the following actions:

- Refuse to grant his license;
- Issue a private or a public reprimand;
- Suspend his license for a set period;
- Restrict his license;
- Revoke his license;
- Condition or withhold doing any of the foregoing if the physician will submit himself to professional care;
- Impose what is essentially a suspended sentence;
- Authorize the reissuing of a license which was suspended or revoked.

Extent of Investigation: The Board and the Joint Secretary have the power to initiate investigation. The investigators are given the power to examine any document concerning the physician's fitness unless the law otherwise prohibits such discovery. The Board President and the Joint Secretary have subpoena power to compel the production of documents and the attendance of witnesses and may obtain a court order to compel obedience to the subpoena. To protect the physician and his patients, information uncovered in such investigations may not be publicized and may not be used for anything other than a hearing before the Board. Any record a physician may have regarding a patient is admissible in the Board hearing to determine the physician's fitness to practice. A physician's patients may be required to testify before the Board. The Board has the power to conduct the hearing in private and to exclude everyone from the hearing room other than those actually involved. If a patient is involved in the hearing, his medical record or testimony must be kept secret.

Hearing Procedures: Any physician against whom a disciplinary proceeding is brought is entitled to adequate prior notice and an opportunity to be fully heard. He may have his attorney present and has the right to present his evidence and witnesses and to cross examine those who testify against him. A physician dissatisfied with any action of the Board has the right to appeal to the courts.

The above is a brief résumé only of a fairly lengthy statute. A physician who may be involved in a disciplinary procedure in any capacity should consult his attorney for a full explanation of the contents of this new law. ■

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

April 6, 1974

EMCRO: Received report on addition of five hospitals to the Discharge Abstract System.

Travel Allowance: Approved increase in the per diem travel allowance from $50 to $75 when attending AMA meetings.

PSRO: Approved extension of the repeal efforts to include repeal of Medicare-Medicaid provisions dealing with PSRO-like review activities. Approved submission of a planning contract for the development of PSRO of Georgia contingent upon approval of the MAG House of Delegates.

Provisional Licensure: Referred to liaison contact with the Board of Medical Examiners the problem of foreign medical graduates being unable to use the M.D. designation.

Appointments: F. Norman Bowles, M.D. as chairman of the Physician-Lawyer Liaison Committee.

I've told this before . . . .

Doc Pritchard, M.D.

SOME 40 OR 50 YEARS AGO, a nondescript white man arrived in our town in South Georgia who soon endeared himself to most of its citizens. He called himself "Doc" Pritchard and that's about all anybody ever knew about Doc. If he had initials, I did not hear of them and he never discussed family or where he grew up. The only thing certain was that he was not a Yankee—one had only to listen to him talk to a stubborn mule to establish this fact.

Doc was quite rich in that his wants were very few and he always seemed content with what he had, which was practically nothing except a few clothes, a great gift for conversation, a ready and contagious laugh, an insatiable love for fishing, all animals, especially mules. He enjoyed an occasional modicum of corn whiskey, especially if he had a cough and it seemed that he could develop one in a flash if he knew or suspected that a bottle was nearby.

He seldom had a regular job because if someone suggested going fishing, anywhere, anytime, he wanted to be ready. The ritual was always the same, he would dig the worms for bait, he would be the man to change flat tires, set up camp if necessary, wash the dishes, etc. It was well known that he never had more than a little change in his pocket and seldom had that, but it would surprise you how many fish he could catch.

He earned his meager livelihood by helping around the livery stables and at the veterinary hospital. As stated before, he loved animals and was a good hand to have around in time of need. He also was a good man when it came to judging the health and stamina of a horse or mule, and because of his work at the veterinary hospital, he learned a little something about their most common ailments and was not above accepting 25 or 50 cents from a poor farmer for treating his mule.

This was why the man who owned the livery stable brought Doc with him to Atlanta to buy a carload of mules. They checked in early one morning at the then Ansley Hotel in downtown Atlanta. It was soon learned that a medical convention was going on because doctors, wearing their badges, were all over the place.

Late that afternoon, after having been at the stockyards all day and having eaten a hearty meal, they are tired and went on to their rooms, but Doc was excited and wanted to walk around some in the bright lights. In the lobby he went over and in his inimitable fashion engaged the clerk in conversation. After a little while the clerk said, "Oh, by the way, doctor, we filled out your badge this morning. but you got away before we could give it to you." The clerk went on to explain that the medical exhibits were around the corner and that the badge was required to get in.

And that's how it came to pass that Doc went back to his room laden with samples of all kinds of medicine, baby food and the like, but most especially a good many samples of a liniment that smelled of wintergreen and was supposed to be very soothing when massaged into swollen and painful joints. The detailman even admitted on being questioned that it probably would help a mule whose joints were "stove-up."

Doc could not let well enough alone, he went back the next night. The dispensers of samples, however, had mulled over some of his unusual conversation of the night before and decided that he was not a doctor. And that was why that when he appeared he was questioned by a Pinkerton guard. Doc readily admitted that he wasn't a doctor—then the guard wanted to know why he registered as Doc Pritchard, M.D.

"Why," Doc said, "that is my name and M.D. means *mule dealer!*"

J. G. McDaniel, M.D.

NEW MEMBERS

Arango, Virgilio A. MAA—Active—PD	35 Linden Ave., N. E. Atlanta, Ga. 30308
Asokan, Sankaran K. Richmond—Active—I	Medical College of Ga. Augusta, Ga. 30902
Barker, Edward C. Hall—Active—FP	Hall County Hospital Gainesville, Ga. 30501
Bigger, John F., Jr. Cobb—Active—OPH	653 Cherokee St. Marietta, Ga. 30060
Bussey, Joseph G. Cobb—Active—SU	5990 Love St. Austell, Ga. 30001
Flanagan, William C., Jr. Muscogee—Active—OBG	2039—10th Ave. Columbus, Ga. 31901
Garrison, Alton F. Richmond—Active—SU	808—13th St. Augusta, Ga. 30901
Hanson, Irvin R., Jr. Cobb—Associate—R	3865 Story Dr. Marietta, Ga. 30060
Harris, Michael N. MAA—Active—FP	400 Colony Square, #1505 Atlanta, Ga. 30361
Jacobson, Alan I. Cobb—Active—PATH	P. O. Box 665 Mableton, Ga. 30059
King, Spencer B., III MAA—Active—C	Emory Univ. Clinic Atlanta, Ga. 30322
Little, Robert C. Richmond—Active—C	Medical College of Ga. Augusta, Ga. 30904
Lowance, David C. MAA—Active—I	46-Fifth St., N. E. Atlanta, Ga. 30308
Marcus, Neal W. MAA—Active—OR	1938 Peachtree Rd., N. W. Atlanta, Ga. 30309
Montes, Ismael G. S. W. Ga.—Active—SU	1605 Shotwell St. Bainbridge, Ga. 31717
Pennington, John A. Cobb—Active—ANES	3112 Bunker Hill Dr. Marietta, Ga. 30062
Politsos, Michael J. MAA—Active—SU	35 Linden Ave., N. E. Atlanta, Ga. 30308
Price, Norma A. MAA—Active—I	960 Johnson Ferry Road, N. E. Atlanta, Ga. 30342
Rao, P. S. Richmond—Active—PdC	Medical College of Ga. Augusta, Ga. 30902
Rose, Fred D. Cobb—Active—I	50 Plaza Way Marietta, Ga. 30060
Snyder, Bruce D. Muscogee—DE4—N	Martin Army Hospital Ft. Benning, Ga. 31905
Spencer, William C., III MAA—Active—R	35 Linden Ave. Atlanta, Ga. 30308
Stapleton, Sidney L., Jr. MAA—Active—VS	735 Piedmont Ave., N. E. Atlanta, Ga. 30308
Stephens, Marvin R. Whitfield-Murray—Active—ANES	Hamilton Memorial Hospital Dalton, Ga. 30720
Villanueva, L. S. MAA—Active—P	Emory University Clinic Atlanta, Ga. 30322
Walker, Leo L., Jr. MAA—Associate—I	2020 LaVista Road, N. E. Atlanta, Ga. 30329
Williams, Theodore G. Dougherty—Active—OR	1105 Palmyra Road Albany, Ga. 31701
Wolff, William A. S. Georgia—Active—OR	Doctors Building Valdosta, Ga. 31601

SOCIETIES

The **Bibb County Medical Society** had as its Witman Lecturer at the April 2 meeting Max Michael, M.D., executive director of the Jacksonville (Florida) Hospitals Education Program. Dr. Michael serves as president of the Association for Hospital Medical Education and chose the topic, "Continuing Education—Fact or Fancy?"

Thirty-eight Bibb County physicians and their wives came by chartered bus to attend MAG's Rally to Repeal PSRO April 7 in Atlanta.

A panel of four DOs addressed the **DeKalb County Medical Society** on the question, "What Is Osteopathy?" for the society's March monthly meeting. An Internal Revenue representative was on hand to answer questions and explain "IRS Problems of Interest to Physicians" for the April 15 meeting.

A public education project by the Society to provide pre-recorded taped health care messages to those who call a number at DeKalb General Hospital is expected to be operational by June 1. "Tel-Med of Atlanta" is being funded the first year by C & S Bank.

As part of its program to feature speakers from fields unrelated to medicine, the **Georgia Medical Society** heard from Mike Tilleman, defensive tackle for the Atlanta Falcons at its March meeting in Savannah. The Society's program committee hopes to increase enthusiasm and attendance at meetings through a series of programs which included speaker Av Weston, vice president of ABC television and news director for net-

work shows at the April 9 meeting. In June a member of the U.S. State Department will present a briefing on the current world political economic struggle.

The GMC's tenth Continuing Education Seminar was held March 19 with Julius Wenger, M.D. as speaker. Dr. Wenger is chief of the Gastroenterology Section of the Atlanta VA Hospital and spoke on "Endoscopy in the Management of Upper Gastrointestinal Hemorrhage."

The April meeting of the **Medical Association of Atlanta** concerned itself with the question "Is Our Private Practice HMO for You?" in a panel presentation led by Charles Todd, M.D., president of the Metropolitan Atlanta Foundation for Medical Care. MAA members were asked to insure emergency medical coverage for foreign visitors during the April 19 through May 5 session of the Organization of American States.

Richmond County Medical Society conducted a March 26 Scientific meeting on "Pre-Operative Evaluation of Renal Functions as a Guide to Postoperative Fluid Management" with Arlie Mansberger, M.D. of the Medical College of Georgia as speaker.

The **South Georgia Medical Society** had as guest speakers for its scientific meeting March 12 George Anthony Richard, M.D., associate professor of pediatrics and director of the Pediatrics-Renal Division of the University of Florida College of Medicine, and Robert Dixon Walker, III, M.D., assistant professor of surgery, Division of Urology and assistant professor in the Department of Pediatrics at the University of Florida. The professors discussed hematuria in childhood and answered questions from the floor.

PERSONALS

First District

Robert J. Di Benedetto and **Paul F. Jurgensen** of Savannah have been elected as Fellows of the American College of Physicians.

Several Savannah physicians have taken over duties as officers on the medical and dental staffs for the following hospitals: St. Joseph's—**J. Robert Logan,** president; **Carl H. Brennan,** vice-president, **O. Emerson Ham, Jr.,** secretary; Candler General—**Dan H. Willoughby,** president, **W. W. Buckhaults,** vice-president, **Thomas L. German,** treasurer; Memorial—**Mason G. Robertson,** president, **David E. Tanner,** president-elect, and **Eloise B. Sherman,** secretary-treasurer.

Specialty board certification has recently come to the following Savannah doctors: **E. F. Downing,** American Board of Neurological Surgery; **Ronald R. Fagin,** Subspecialty Board of Gastroenterology; **Morris A. Kugler,** American Board of Surgery; **John H. West,** Subspecialty Board of Medical Oncology; and **Leslie L. Wilkes,** American Board of Orthopedics.

Third District

Morton P. Berenson, Columbus, is a new Fellow of the American College of Physicians.

Columbus Radiologist **J. H. Walker Harris,** a Tulane

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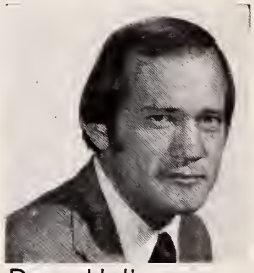




Jim Andrews



Steve Eades



Doug Hall



Wayne Horne



Bill Young

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Medical School graduate now associated with St. Francis Hospital and the Medical Center, has been named a Fellow in the American College of Radiology.

Fifth District

John C. Hall of Atlanta has been named a Fellow in the American College of Physicians.

Brit B. Gay, Jr., Decatur, is a new Fellow in the American College of Radiology. Dr. Gay is a graduate of Emory University School of Medicine, and is affiliated with Henrietta Egleston Hospital for Children, Emory University and Grady Memorial hospitals.

W. Brem Mayer, Atlanta, has been certified by the American Board of Electroencephalography, the first physician in the state to receive the title.

New chief of surgery at Piedmont Hospital is **Charles S. Jones.**

Cecil Dixon Warren has been appointed director of the Mental Health Division of the Fulton County Health Department.

Ralph C. Williams, Sr., Atlanta, is the author of "Leslie L. Lumsden, M.D.: Pioneer in Rural Sanitation and Early Epidemiology in the United States" which appeared in the April *Southern Medical Journal.* Dr. Lumsden was a career medical officer in the U. S. Public Health Service and retired as Assistant Surgeon General in 1951.

Sixth District

The American College of Physicians has announced that **Robert B. Copeland** of LaGrange has been named a Fellow.

Thomas H. Williams of Macon is the newly-elected president of the Georgia chapter of the American College of Surgeons.

Seventh District

William H. Mathis, Jr. and **Donald R. Rooney** of Marietta were recently honored at the 51st Annual meeting of the American College of Radiology in New Orleans. Dr. Mathis has been named a Fellow in the College. He is a graduate of the Medical University of South Carolina and is affiliated with Kennestone Hospital in Marietta. Dr. Rooney, a graduate of Emory University, was elected to a three-year term on the Board of Chancellors. Dr. Rooney is past president of the Cobb County Medical Society and the Georgia Radiological Society.

Tenth District

Albert A. Carr and **Paul E. Cundey** have been named Fellows of the American College of Physicians.

Alfred Jay Bollet, professor and chairman of the Department of Medicine at the Medical College of Georgia in Augusta has been named chairman of the Department of Medicine at Downstate Medical Center in Brooklyn, N. Y. effective July 1.

Perry P. Volpitto, professor emeritus of the Department of Anesthesiology at the MCG, spoke on "Catalysts of Twentieth Century Anesthesiology" at the 10th

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annual postgraduate course on "Inhalation Anesthetics" at Emory University in April.

Elected into fellowship on the American College of Obstetricians and Gynecologists is **George P. Williams** of Augusta. Dr. Williams is on the staffs of St. Joseph's, University and Doctors hospitals.

DEATHS

Walter Edward Brown

Walter Edward Brown, of Savannah, president of the Medical Association of Georgia in 1966-1967, died March 14 in Candler General Hospital in Savannah.

The Sharon native had practiced in Savannah since 1931 and had served as president of the Georgia Medical Society. Dr. Brown was head of Candler Hospital medical staff in 1950 and 1959, a member of the Georgia State Medical Board of Workmen's Compensation and was medical director for Savannah's Union Camp Corporation. He was named General Practitioner of the Year several years ago.

Survivors include his widow, Mrs. Neva Barber Brown; daughter, Mrs. William R. Egan of Atlanta; son, Dr. W. E. Brown, Jr., of Nashville; sister; two brothers; and two grandchildren.

Gordon Chason

Bainbridge physician Gordon Chason died March 8, the day following his 98th birthday.

Dr. Chason was born in 1876 in Decatur County, what is now Seminole County, the son of pioneer citizens Mr. and Mrs. Reuben Chason. He attended Mercer University and the University of Louisville Medical School.

He began practice in Bainbridge in 1901 with his brother, Jeff D. Chason, M.D., and together they established Riverside Hospital in 1918.

Dr. Chason served four terms on the City Council of Bainbridge and was a life Deacon of the First Baptist Church. He served for many years on the Board of Directors of the First State National Bank.

Survivors include his daughter, Mrs. Cornelia Chason Miller of Bainbridge; two grandchildren, Gordon Chason Miller, M.D. of Columbus and Mrs. Charles W. Beggerow of Kingsport, Tenn.

Rufus Elliott Graham

Rufus Elliott Graham, who began practice in Georgia in 1904, died March 28 in Savannah at the age of 99.

Dr. Graham was born in Effingham County and attended the University of Georgia, receiving his M.D. degree from Maryland Medical College in Baltimore, Md. in 1904. He was a member of medical associations at local, state and national levels and was active in the American Legion.

Survivors include two daughters, Mrs. David W. Sutfin and Mrs. Theron R. Wannamaker of Savannah: brother, E. J. Graham of Statesboro; grandson and three great-grandchildren.

McClaren Johnson, Jr.

McClaren Johnson, Jr. died November 7, 1973 at the age of 39. He was a physician at the Student Infirmary of Georgia Institute of Technology. His B.S.

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and M.D. degrees were earned at Emory and postgraduate training was completed at the Emory-VA program. Dr. Johnson had talents in the area of art and medical illustration and served as an aid in graphic design for *Atlanta Medicine*.

Peter S. Kwiatkowski

Capt. Peter S. Kwiatkowski, U. S. Navy retired, of Brunswick, died February 13 while attending a meeting in Augusta.

Dr. Kwiatkowski served as deputy director at the Glynn County Board of Health.

Survivors include his widow, Mrs. Stella Kwiatkowski; three sons; sister, Mrs. Wanda Stern; brother, Joseph F. Kwiatkowski; mother, Mrs. Petronela Kwiatkowski, all of Binghamton, N. Y.; and several cousins.

William Bates McMath, Sr.

Americus physician William Bates McMath, Sr., 63, died March 13 in Americus and Sumter County Hospital following an apparent stroke.

The ophthalmologist was born in Americus and was graduated from Emory University School of Medicine, serving his residency at Grady Hospital in Atlanta.

Dr. McMath was a Fellow of the American Academy of Ophthalmology and Otolaryngology and a Fellow of the American College of Surgeons. He was a member of the First United Methodist Church and Rotary Club of Americus.

He is survived by his widow, Mrs. Henryetta Glover McMath; and son, Bill McMath, Jr.; five sisters and two brothers.

William Joseph Williams

Augusta physician William Joseph Williams, 68, died February 14.

Dr. Williams was born in Lincoln County, received his B.A. degree from Mercer University and M.D. from the Medical College of Georgia. He served in the U. S. Navy during World War II.

Dr. Williams was a Fellow of the American College of Surgeons, past president of the Richmond County Medical Society and former clinical instructor at the Medical College.

Dr. Williams is survived by his widow, Mrs. Elizabeth Taylor Williams, Augusta; two daughters, Mrs. L. D. Evans, III of Augusta and Mrs. Harvey L. Turner of Atlanta; three brothers; three sisters.

Doctor's Day Celebrations Dot the State

Proclamations were signed, red carnations slipped into buttonholes and festive dinners served to husbands as Auxiliary members across the state led the observances of Doctors' Day March 30.

The occasion, now celebrated in many states and nations, grew from the desire of one Georgia physician's wife to honor her husband and his peers for their humanitarian works. Mrs. Charles B. (Eudora Brown) Almond of Winder spearheaded the project which led the Barrow County Auxiliary to first adopt March 30 as Doctors' Day in 1933. The MAG Auxiliary adopted a resolution making the observance official throughout the state the next year. Soon the Southern Medical Auxiliary followed suit, and finally in 1958 the U.S. Congress passed a resolution designating Doctors' Day nationwide.

March 30 was not chosen at random, but specifically —it is the day on which in 1842 Crawford W. Long, M D. first used sulphuric ether as an anesthetic during a surgical operation.

This year members of the Woman's Auxiliary to MAG, including Mrs. Almond, participated in ceremonies at the Capitol in which Gov. Jimmy Carter officially proclaimed Doctors' Day. **DeKalb** Auxiliary members secured the signature of A. C. Guhl, county commissioner, to another proclamation. This auxiliary also provided coffee in the area hospitals and held a progressive dinner hosted by Mrs. James Walker, Mrs. John McLane and Mrs. Roy Vandiver. Especially honored in this year's observance was Fletcher McGeachy, M D., DeKalb physician who died in 1973. Dr. McGeachy had served as president of the Emory University Hospital staff and the DeKalb Medical Society.

Baldwin County Auxiliary honored its physicians with a buffet supper at the Tomlinson-Fort House. Doctors' wives in the **Carroll-Douglas-Haralson** area presented physicians with red carnations, served coffee and doughnuts at the Villa Rica City Hospital and placed flowers in memory of Drs. J. E. Powell, Sr. and J. I. Vansant. A dinner for the physicians was given at the home of Dr. and Mrs. Ed Grant in Carrollton.

Doctors' Day was celebrated by the **Trion** Community Hospital staff with a dinner honoring its doctors. The **Glynn** County Medical Auxiliary donated funds to the physicians library at Brunswick Junior College for the purchase of a medical reference book. This material will be given in the memory of Peter Kwiatkowski, M.D. who died in February. An additional contribution was to be made to the American Medical Association Education Research Foundation. Two local physicians who have been in active practice for more than 50 years, Drs. C. S. Britt and C. W. Lupo were given special recognition that day.

Richmond County observed Doctors' Day by delivering a red carnation to those with 40 years or more of practice and through a dinner dance at the Officers Club at Fort Gordon. **Stephens** County physicians were also honored with a special dinner at the First Presbyterian Church in Toccoa.

Tift County Auxiliary members honored their husbands with a present of carnations, treated them to a fishing contest on Tift County lake and prepared an appreciation dinner at the Elk's Lodge. The late Carlton Fleming was given a special tribute at the dinner. **Worth** County wives also observed the day be presenting carnations and placing flowers in a local church in honor of deceased doctors of the area.

Classifieds

RATES AND DATA: Space sells at a rate of $5 for 50 words or less for members and $10 for 50 words or less for non-members, payable in advance, with a charge of 10 cents for every extra word. For replies, your name, address and phone number should be included at the end, or an Ad number at the *Journal* may be substituted at no extra cost. Copy and payment should be received by the 20th of the month preceding publication. Mail to the *Journal of the Medical Association of Georgia*, 938 Peachtree St., N.E., Atlanta, Ga. 30309.

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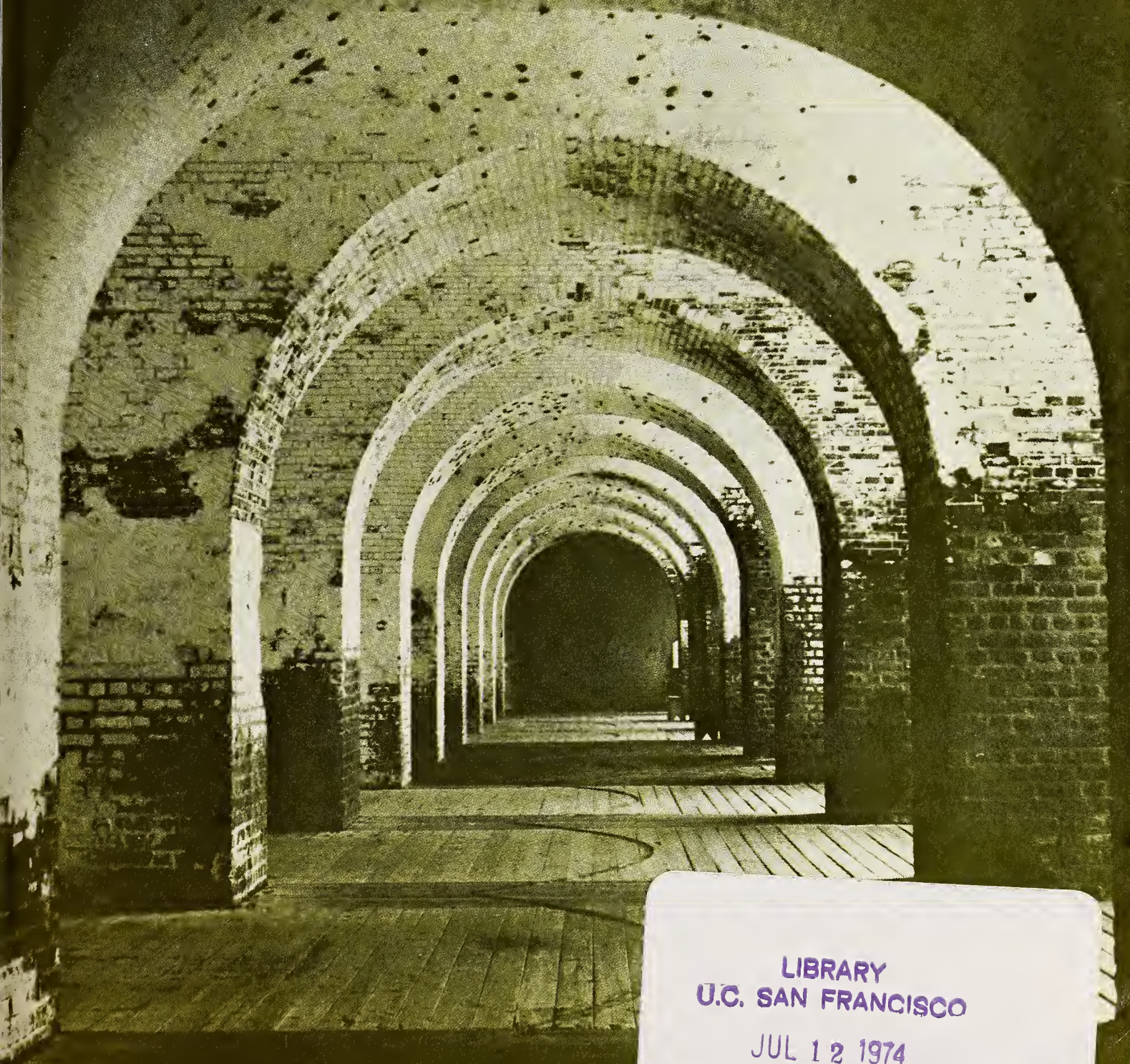
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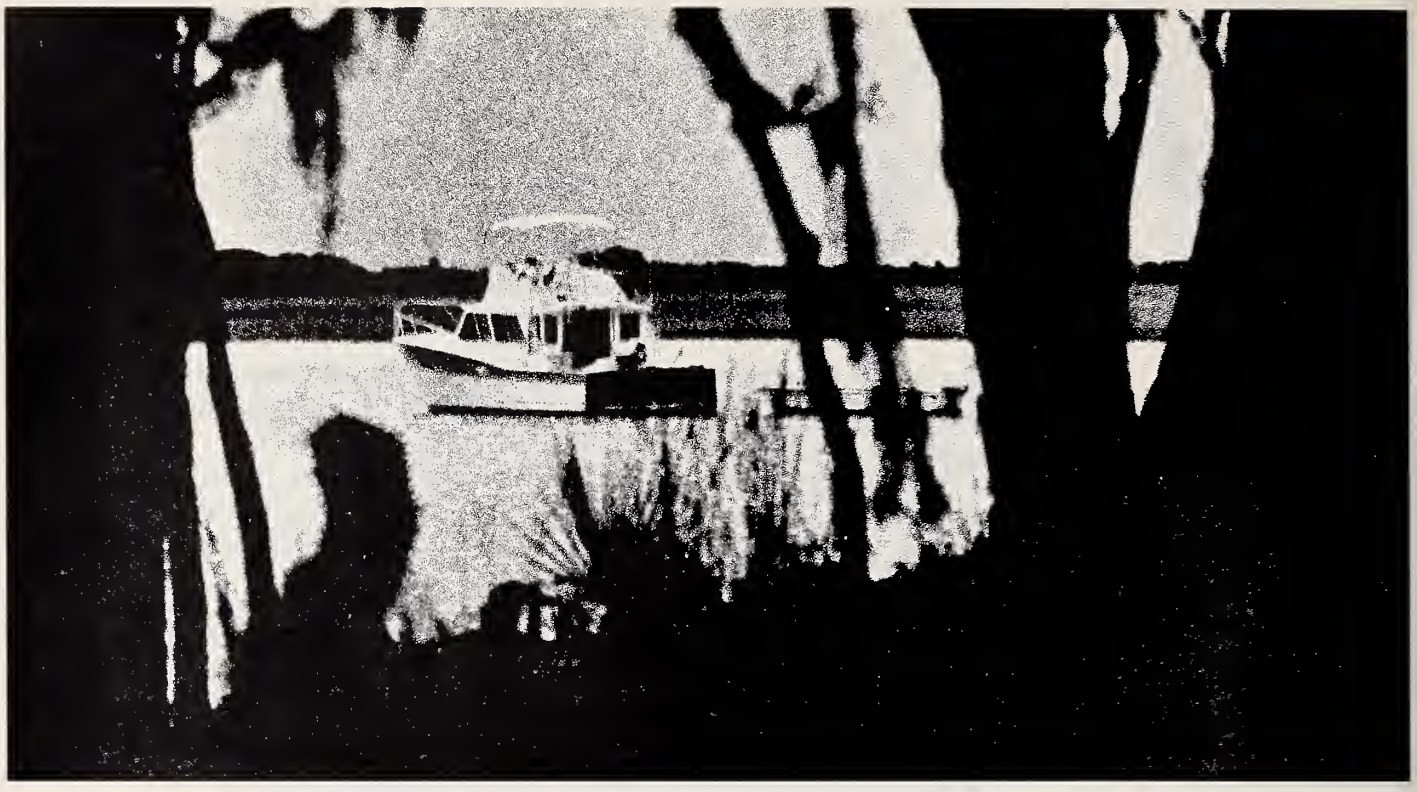
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THE COVER

Savannah's Fort Pulaski, Robert E. Lee's first engineering assignment after graduation from West Point, is a study in the beauty of symmetry as we again salute the 1974 Annual Session host city. Layout by Atlanta artist Bob Hamill.



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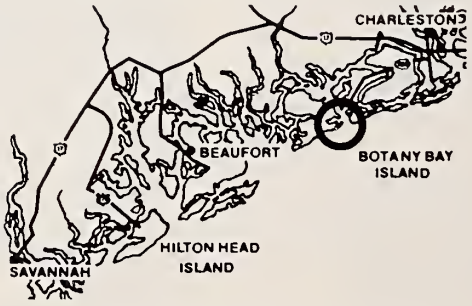
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JOURNAL
of the medical association of
georgia

MAG First General Session

1974 Annual Session Business Meeting
Friday, May 10, 1974

The First General Session of the 1974 Annual Session Business Meeting of the Medical Association of Georgia was called to order by President C. E. Bohler, M.D., Brooklet, at 9:00 a.m. in the Ballroom of the DeSoto Hilton Hotel, Savannah, Georgia, on May 10, 1974.

Dr. Bohler welcomed those present and called upon J. W. Chambers, M.D. for the invocation.

Following the invocation, he asked Carson Burgstiner, M.D. to lead the group in the pledge of allegiance to the flag.

Dr. Bohler then recognized Fenwick Nichols, M.D., president of the Georgia Medical Society, to extend his greetings and the official welcome of this society to the Medical Association of Georgia.

He acknowledged the presence of two guests and asked them to stand to be recognized. They were Mr. Fred Higginbotham, president of Atlanta Blue Cross/Blue Shield, and Mrs. Claudia Welch, representing the Georgia Nurses Association.

At this point, Dr. Bohler requested Braswell Collins, M.D. of Macon to escort Mrs. John Bates, president of the Woman's Auxiliary of the Medical Association of Georgia, to the podium. Mrs. Bates gave a report on the activities of the Auxiliary and concluded her remarks by introducing two special guests, Mrs. Howard Liljestrand of Honolulu, Hawaii, president-elect of the Woman's Auxiliary to the AMA; and Mrs. W. Nash Thompson of Stuart, Virginia, president of the Woman's Auxiliary to the Southern Medical Association. Dr. Collins escorted Mrs. Liljestrand to the podium and she delivered brief remarks, extending greetings from the AMA Auxiliary.

Dr. Bohler called on J. Rhodes Haverty, M.D. of Atlanta, president-elect of the Medical Association of Georgia, to deliver the address of the incoming President of the Association.



Urging physicians to work more closely with their wives in projects of concern to the medical profession is Mrs. Howard Liljestrand of Hawaii, president-elect of the AMA Auxiliary.

At the conclusion of his address, Dr. Bohler thanked Dr. Haverty for his thought-provoking message and proceeded with several announcements including the GaMPAC breakfast scheduled for Saturday morning, the President's reception scheduled for Saturday night and the Medicare-Medicaid Workshop to be conducted on Friday afternoon.

At this point, Dr. Bohler recessed the First Session of the MAG Annual Session and turned the gavel over to Harrison L. Rogers, Jr., M.D. of Atlanta, speaker of the MAG House of Delegates, to preside at the First Session of the House of Delegates meeting.

First Session House of Delegates

Friday, May 10, 1974

The First Session of the House of Delegates was called to order by Speaker Harrison L. Rogers, Jr., M.D. of Atlanta at 10:00 a.m. in the Ballroom of the DeSoto Hilton Hotel in Savannah, Georgia, on Friday, May 10, 1974. The Speaker extended greetings to all delegates in attendance and briefly reviewed the schedule for the transaction of business by the House of Delegates during its two sessions on Friday, May 10, and Sunday, May 12, 1974.

Speaker Rogers called for a report of the delegates in attendance. Richard L. Benson, M.D. of Douglas, Georgia, chairman of the Credentials Committee, reported that there were 89 delegates present and, accordingly, announced that a quorum of the House existed. (A final tally by the Credentials Committee indicated 120 delegates in attendance at the First Session.)

Attendance

BALDWIN: W. T. Smith and Edwin W. Allen, Jr.; BARTON: R. A. Griffin, III; BIBB: C. A. Duggan, John G. Etheridge, Jasper T. Hogan, C. G. Magnan, Jr., Jack Menendez, S. Charlotte Neuberg, W. John O'Shaughnessey and B. B. Sanders; OGEECHEE RIVER: Charles R. Richardson; CARROLL-DOUGLAS-HARALSON: J. Larry Boss and Clark Robinson; GEORGIA MEDICAL SOCIETY: Frank M. Johnston, J. Patrick Evans, D. A. Nash, Thomas A. Hetherington, J. Robert Logan, J. Moultrie Lee and F. D. Maner; ELBERT: Carey A. Mickel, Jr.; CHATTAHOOCHEE: Rupert H. Bramblett and Cecil L. Miller; CHEROKEE-PICKENS: L. Austin Flint; CLAYTON-FAYETTE: Wells Riley; COBB: C. R. Underwood, James H. Manning, J. Gary Palmer, J. Norman Bowles, Robert P. Coggins, Harry Porter, Jr. and Charles J. Rey, Jr.; COFFEE: Richard L. Benson; DEKALB: Timothy Harden, Jr., L. L. Freeman, William J. Rawls, C. W. McDowell, LaMar S. McGinnis, H. Duane Blair, Roy W. Vandiver, William R. Hardcastle, Stanley P. Aldridge and L. C. Buchanan; DOUGHERTY: Robert D. Waller, J. D. Bateman, Charles D. Hollis and D. M. Boyette; EMANUEL: R. J. Moye; FLINT: J. T. Christmas; FLOYD-POLK-CHATTOOGA: James H. Smith and Charlie O. Sennett; MEDICAL ASSOCIATION OF ATLANTA: W. W. Moore, Stewart Weigand, John M. McCoy, Howard S. Brown, L. H. Felder, W. C. Waters, John R. McCain, Edward J. Waits, F. W. Dowda, Edwin C. Evans, James A. Kaufmann, E. L. Graydon, Thomas L. Tidmore, Fleming Jolley, Robert L. Brown, W. D. Logan, W. Dan Jordan, C. R. Moorhead, John S. Atwater, John K. Schellack, John Rhodes Haverty, Armand Hendee, Joseph S. Wilson and J. R. B. Hutchinson; GLYNN: Michael A. Glucksman, Ben T. Galloway and W. Jack Smith; HALL: Harvey M. Newman, Larry N. Durisch and Charles K. Bradley; JACKSON-BANKS: Paul O. Scoggins; LAURENS: O. B. Johnson and Robert W. Oliver; MCDUFFIE: Thomas E. Averitt; MUSCOGEE: E. M. Molnar, Bruce C. Newsom, B. R. Maughon, John H. Deaton, James H. Sullivan and J. A. Raines; OCONEE: H. A. Thornton; RANDOLPH-STEWART-TERRELL: John G. Bates; RICHMOND: Luther M. Thomas, Jr., Preston D. Ellington, Ronald F. Galloway, Stuart H. Prather, Jr., J. Kenneth McDonald, Thomas G. Douglass, Henry D. Scoggins, Joseph P. Bailey, Jr., John M. Martin and Claud Boyd; SPALDING: H. A. Foster and James M. Skinner; STEPHENS: C. P. Lampros; SUMTER: E. W. Waldemayer; TIFT: W. O. Holloway; TROUP: H. Hilt Hammett, Jr., and Joseph M. Almand, Jr.; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: M. K. Cureton and Ted D. Cash; WARE: S. William Clark; WAYNE: Ollie O. McGahee; WHITFIELD-MURRAY: Earl T. McGhee and James J. Oosterhoudt; WILKES: M. C. Adair; SAMA: Joseph Kennan.

Speaker Rogers thanked the Chairman of the Credentials Committee, announced that the business of the House could now proceed and requested that delegates only be seated in the front portion of the House in order to easily distinguish voting members from the guests.

Dr. Rogers presented L. C. Buchanan, M.D., vice speaker of the House of Delegates, and subsequently explained in detail the methods for consideration of business that would be brought before the House of Delegates.

Speaker Rogers announced the appointment of the House of Delegates Credentials Committee and the appointment of the Tellers Committee of the House as follows:

CREDENTIALS COMMITTEE: Richard L. Benson, Douglas, chairman; Bruce C. Newsom, Columbus; Thomas L. Tidmore, Atlanta.

TELLERS COMMITTEE: Henry A. Foster, Griffin, chairman; Louis Felder, Atlanta; Lee Parker, Greensboro.

The Speaker appointed the following House of Delegates Reference Committees:

REFERENCE COMMITTEE A: R. J. Moye, Swainsboro, chairman; J. H. Smith, Rome, vice chairman; J. Moultrie Lee, Savannah; Cecil L. Miller, Buford; J. Gary Palmer, Marietta; W. D. Logan, Atlanta.

REFERENCE COMMITTEE B: S. W. Clark, Waycross, chairman; T. N. Lumsden, Clarksville, vice chairman; Frank L. Wilson, Atlanta; Harvey Newman, Gainesville; G. W. Merritt, Vidalia; Charles McDowell, Decatur.

REFERENCE COMMITTEE C: W. C. Waters, III, Atlanta, chairman; Lucien A. Flint, Canton, vice chairman; Joseph M. Almand, LaGrange; J. Kenneth McDonald, Augusta; Lewis R. Collins, Newnan; James J. Oosterhoudt, Dalton.

REFERENCE COMMITTEE D: W. John O'Shaughnessey, Macon, chairman; J. A. Mulherin, Savannah, vice chairman; John B. O'Neal, Elberton; W. Jack Smith, Brunswick; John C. Hall, Atlanta; Wells Riley, Jonesboro.

REFERENCE COMMITTEE F: Duane Blair, Decatur, chairman; Stuart H. Prather, Augusta, vice chairman; James H. Manning, Marietta; John S. Atwater, Atlanta; Robert D. Waller, Albany; James H. Sullivan, Columbus.

To expedite the adoption of the minutes of the 1973 Special Session of the House of Delegates (December 15-16, 1973) at the Marriott Motor Hotel in Atlanta, Georgia, the Chair entertained a motion that the minutes as published in the January issue of the *Journal of the Medical Association of Georgia* be approved. On motion duly made and seconded, it was voted that these minutes be approved as published. The Speaker reminded the House that they had approved the minutes of the 1973 Annual Session at the time the House met in Special Session in December.

Nominations

Speaker Rogers called on the House to proceed with the nominations of officers, AMA delegates and alternates, speaker and vice speaker of the House of Delegates and requested that nominating speeches be limited to two minutes and seconding speeches be limited to one minute.

The Speaker asked for nominations for the office of MAG president-elect and the following nomination was made:

PRESIDENT-ELECT: David A. Wells, Dalton, nominated by Earl T. McGhee. Dr. Wells' candidacy was seconded by F. G. Eldridge and L. C. Buchanan.

There being no further nominations for the office of president-elect on motion duly made and seconded the nominations were closed.

SECOND VICE PRESIDENT: W. Daniel Jordan, Atlanta, was nominated for the office of second vice president by J. Harold Harrison. Dr. Jordan's candidacy was seconded by Jack Menendez.

Joseph M. Almand, LaGrange, was nominated by H. Hilt Hammett, LaGrange. Dr. Almand's candidacy was seconded by Ollie McGahee and Earl T. McGhee.

There being no further nominations for the office of MAG second vice president on motion duly made and seconded the nominations were closed.

The Speaker asked for nominations for the office of speaker of the House of Delegates and the following nominations were made:

SPEAKER: L. C. Buchanan, Decatur, was nominated for the office of speaker of the House of Delegates by LaMar McGinnis. Dr. Buchanan's candidacy was seconded by F. William Dowda and Earnest C. Atkins.

There being no further nominations for the office of speaker of the House of Delegates on motion duly made and seconded, the nominations were closed.

The Speaker asked for nominations for the office of MAG vice speaker of the House of Delegates and the following nominations were made:

VICE SPEAKER: Ronald F. Galloway, Augusta, was nominated by Luther M. Thomas. Dr. Galloway's candidacy was seconded by J. W. Chambers, R. J. Moye, Ollie O. McGahee, John Kirk Train, J. Kenneth McDonald, Luther Vinton, James Smith and Fleming Jolley.

Jack Raines, Columbus, was nominated by Robert Maughon. Dr. Raines' candidacy was seconded by W. W. Moore, L. C. Buchanan, James Sullivan and Fleming Jolley who rose to announce that he wishes to nominate both Dr. Galloway and Dr. Raines for this job.

There being no further nominations for the office of vice speaker of the House of Delegates, on motion duly made and seconded the nominations were closed.

COUNCILORS AND VICE COUNCILORS: Speaker Rogers then quoted from Chapter V, Section 2 of the Bylaws which authorize the election of councilors and vice councilors from district societies and component county medical societies, observing that the following district medical societies and county medical societies had complied with the terms of the Bylaws and had accordingly elected the following councilors and vice councilors:

Sixth District Councilor: James M. Skinner, M.D., Griffin (1977); Vice Councilor: Norman P. Gardner, M.D., Thomaston (1977).

Seventh District Councilor: Don Schmidt, M.D., Cedartown (1977); Vice Councilor: Richard A. Griffin, III, M.D., Cartersville (1977).

Eighth District Councilor: Robert E. Perry, M.D., Brunswick (1977); Vice Councilor: Joe C. Stubbs, M.D., Valdosta (1977).

Medical Association of Atlanta Councilor: John T. Godwin, M.D., Atlanta (1977); Vice Councilor: J. Norman Berry, M.D., Atlanta (1977).

Muscogee County Medical Society Councilor: Jack A. Raines, M.D., Columbus (1977); Society Vice Councilor: Louis Hazouri, M.D., Columbus (1977).

AMA Delegates

Speaker Rogers called for nominations for MAG delegates to the American Medical Association. He observed that all incumbents would serve until December 31, 1974, at which time the new term of office would begin for the candidates elected at this meeting.

AMA DELEGATE: For the office held by Preston D. Ellington, Augusta, the term beginning January 1, 1975, and expiring December 31, 1977. J. Daniel Bateman, Albany, was nominated by Robert Waller and seconded by C. E. Bohler and Luther M. Thomas.

There being no further nominations for this office on motion duly made and seconded, it was voted to close the nominations.

AMA DELEGATE: For the unexpired term of office held by J. Frank Walker, Atlanta, the term beginning May 12, 1974, and expiring December 31, 1974. Harrison L. Rogers, Atlanta, was nominated by Edwin C. Evans and seconded by Stuart Prather, John O'Shaughnessey, F. William Dowda and Thomas Tidmore.

There being no further nominations for the office on motion duly made and seconded, the nominations were closed.

AMA DELEGATE: For the office held by J. Frank Walker, Atlanta, the term beginning January 1, 1975, and expiring December 31, 1976. Harrison L. Rogers, Atlanta, was nominated by Edwin C. Evans and on motion duly made and seconded, the nominations were closed.

AMA ALTERNATE DELEGATE: For the office held by J. Daniel Bateman, Albany, the term to begin on January 1, 1975, and expiring on December 31, 1976. C. Emory Bohler was nominated by Earnest C. Atkins and seconded by J. Rhodes Haverty and Claud Boyd.

There being no further nominations for the office duly made and seconded, the nominations were closed.

AMA ALTERNATE DELEGATE: For the office held by F. William Dowda, Atlanta, the term beginning January 1, 1975, and expiring December 31, 1976. F. William Dowda was nominated by William D. Logan and seconded by Edwin C. Evans and John McCain.

There being no further nominations for this office on motion duly made and seconded, the nominations were closed.

On a point of personal privilege, Dr. Dowda rose to thank the House for the confidence they had shown in him during the past six years by electing him to various offices in the Association.

Annual Reports

Speaker Rogers called for the Annual Report of the MAG officers, council, councilors, vice councilors, AMA delegates, Association committees and other reports to be introduced at this session which are listed below with the Reference Committee to which these reports were referred appropriately indicated. The Speaker observed that the complete report, the action of the Reference Committees and the subsequent action taken by the House of Delegates on each report would be found under the proceedings of the Second Session of the House of Delegates on all of those reports and resolutions which were referred to Reference Committees. (See pages 232-272.

OFFICERS

President—Reference Committee B
Immediate Past President—C
President-Elect—C
First Vice President—A
Second Vice President—B
Secretary—B
Treasurer—F
Speaker of the House—B

COUNCILORS AND VICE COUNCILORS

Chairman of Council—Reference Committee B
First District Councilor—Not Referred
Second District Councilor—Not Referred
Third District Councilor—Not Referred
Sixth District Councilor—Not Referred
Seventh District Councilor—Not Referred
Eighth District Councilor—Not Referred
Ninth District Councilor—Not Referred
Tenth District Councilor—Not Referred
Bibb County Councilor—A
Cobb County Councilor—Not Referred
DeKalb County Councilor—A
Georgia Medical Society Councilor—A
MAA Councilors—Not Referred
Muscogee County Councilor—Not Referred
Richmond County Councilor—Not Referred

ASSOCIATION COMMITTEES

Annual Session—Reference Committee D
Constitution and Bylaws—B
Finance (1974-75 Budget)—F
Pro. Conduct and Medical Ethics—Not Referred
Emergency Medical Services—Not Referred
Cancer—Not Referred
Communications—A
Education—C
Insurance and Economics—Not Referred
National Legislation—Not Referred
State Legislation—Not Referred
Maternal and Infant Welfare—B
Medicine and Religion—Not Referred
Mental Health—Not Referred
Occupational Health—Not Referred
Peer Review—Not Referred
Physician-Lawyer Liaison—D
Private Practice—Not Referred
PSRO—C
Public Health—D
Quackery—B
Rural Health—A
School Child Health—Not Referred
Ad Hoc Committee to Study Building and Land—F
Ad Hoc Committee on Access to Health Care—A
Ad Hoc Committee on Organization and Functions—B

SPECIAL REPORTS

EMCRO—Reference Committee C
Georgia Medical Care Foundation—C
Georgia Regional Medical Program—Not Referred
Interspecialty Council—Not Referred
Journal—Not Referred
Woman's Auxiliary to the Medical Association of Georgia—F

The Speaker then proceeded with unfinished business calling for submission of supplemental reports from officers, councilors and committee chairmen.

SUPPLEMENTAL REPORTS

Supplemental Report 74-1: Report of the Secretary—Reference Committee F

Supplemental Report 74-2: Committee on Education (Nursing)—Not Referred
Supplemental Report 74-3: Committee on Education—B
Supplemental Report 74-4: Committee on State Legislation—B
Supplemental Report 74-5: Committee on Cancer—Not Referred
Supplemental Report 74-6: Constitution and Bylaws—B
Supplemental Report 74-7: Constitution and Bylaws—B
Supplemental Report 74-8: PSRO Committee—C

Speaker Rogers called attention to the reports which were shown as having no recommendations and thus had not been referred to any Reference Committee. He told the delegates that they could request that any report be referred but no requests were received from the floor. At this point the Speaker recognized Earnest Atkins, M.D., secretary, who moved that the First Session of the House of Delegates accept with commendation and file for information all reports that had not been specifically referred to a Reference Committee. This motion was duly seconded and adopted by the House. The Speaker then announced that all reports not referred to Committee would be filed for information. They are as follows:

FIRST DISTRICT COUNCILOR

Albert M. Deal, M.D.

Being new on Council, my contributions have been negligible. I have attended some of the meetings and my Vice-Councilor, in whom I am well pleased, has had no trouble in filling the seat. It would seem that our combined efforts to provide broad involvement in medical disciplinary problems as well as sick physicians has been successful. Possibly by the time we meet it will have been signed into law.

FIRST DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1972 MAG	Members December 31, 1972 AMA Dues Paying Only	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only
Ogeechee River Robert B. Stambuk Statesboro	22	20	23	21
Burke Charles Green Waynesboro	7	5	6	4
Emanuel D. L. Kennedy Adrian	6	5	5	4
Laurens Grady E. Longino Dublin	41	26	42	23
Screven James C. Freeman Sylvania	5	5	5	4
Southeast Georgia Travis R. Nobles Vidalia	14	9	13	10
	95	70	94	66

SECOND DISTRICT COUNCILOR

J. Daniel Bateman, M.D.

SECOND DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1972 MAG	Members December 31, 1972 AMA Dues Paying Only	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only
Colquitt Thomas R. Hester, Jr. Moultrie	15	13	19	17
Decatur-Seminole M. A. Ehrlich Bainbridge	14	7	13	9
Dougherty T. Gray Fountain Albany	79	59	88	69
Mitchell A. A. McNeill, Jr. Camilla	3	3	4	4
Southwest Georgia David Wetherby Fort Gaines	12	8	10	7
Thomas Area Thomas F. Lear Thomasville	52	45	55	46
Tift Sam Dixon Tifton	22	15	23	13
Worth Robert T. Morgan Sylvester	5	3	5	3
	202	153	217	168

THIRD DISTRICT COUNCILOR

John H. Robinson, III, M.D.

As a member of MAG Council from the Third District I send this report.

Either the member of Council and/or the Vice-Council has attended the majority of meetings during the year.

We share the view that the private practice of medicine in 1974-75 faces its most serious time and urge all members to stick together to protect our rights Let us support that which is good and resist that which is bad.

THIRD DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1972 MAG	Members December 31, 1972 AMA Dues Paying Only	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only
Flint	13	12	13	12
Peach Belt	42	35	40	35
Randolph-Stewart-Terrell	10	10	10	10

Sumter	29	20	27	18
	94	77	90	75

SIXTH DISTRICT COUNCILOR

W. E. Barron, M.D.

SIXTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1972 MAG	Members December 31, 1972 AMA Dues Paying Only	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only
Clayton-Fayette F. A. Sams, Jr. Fayetteville	10	9	19	15
Coweta Lewis R. Collins Newnan	22	13	20	15
Meriwether-Harris William G. Chambless Hamilton	16	13	16	14
Spalding William V. Smith Griffin	47	41	46	39
Troup C. P. Major LaGrange	40	30	41	33
Upson Pratoon Pratitong Thomaston	18	16	18	16
	153	122	160	132

SEVENTH DISTRICT COUNCILOR

David A. Wells, M.D.

SEVENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1972 MAG	Members December 31, 1972 AMA Dues Paying Only	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only
Bartow Virginia Hamilton Cartersville	11	6	11	6
Carroll-Douglas-Haralson Mary J. Touchton Carrollton	39	36	36	33
Floyd-Polk-Chattooga John R. Lovvorn Rome	94	68	93	70
Gordon Frank M. Alvarez Calhoun	10	9	11	10
Walker-Catoosa-Dade M. K. Cureton LaFayette	36	19	36	21
Whitfield Paul L. Bradley Dalton	54	45	56	45
	244	183	243	185

EIGHTH DISTRICT COUNCILOR

Robert E. Perry, Jr., M.D.

EIGHTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1972 MAG	Members December 31, 1972 AMA Dues Paying Only	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only
Altamaha	5	5	6	6
Ben Hill-Irwin	8	8	7	7
Coffee	9	7	9	9
Camden-Charlton	8	4	6	4
Glynn	55	47	59	49
Ocmulgee	15	13	18	15
South Georgia	65	51	72	52
Telfair	5	4	4	4
Ware	48	43	44	39
Wayne	15	9	9	12
	233	191	234	197

NINTH DISTRICT COUNCILOR

Paul T. Scoggins, M.D.

NINTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1972 MAG	Members December 31, 1972 AMA Dues Paying Only	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only
Barrow W. Jack Dickens Winder	8	7	8	7
Blue Ridge H. E. Mitzelfelt Blue Ridge	5	4	5	4
Chattahoochee Rupert H. Bramblett Cumming	24	19	26	22
Cherokee-Pickens Carlton B. Hudson Canton	14	14	17	15
Elbert-Franklin-Hart Jack Hands Elberton	15	10	8	5
Habersham L. G. Hicks, Jr. Clarkesville	10	6	10	6
Hall John Garland Gainesville	70	60	74	66
Jackson-Banks S. A. Vickery Commerce	9	7	9	7
Rabun John T. Crenshaw Clayton	5	5	4	4
Stephens Robert W. Slate Toccoa	21	17	21	18
	181	149	182	154

TENTH DISTRICT COUNCILOR

Edwin W. Allen, Jr., M.D.

TENTH DISTRICT MEMBERSHIP

Counties and Secretaries	Members December 31, 1972 MAG	Members December 31, 1972 AMA Dues Paying Only	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only
Baldwin David Cardoso Milledgeville	56	33	56	28
Crawford W. Long Paul S. York Athens	77	58	86	70
Jefferson James W. Pilcher Louisville	5	4	7	6
McDuffie William L. Vaughan Thomson	5	5	5	5
Newton-Rockdale Karl S. VonSenden, Jr. Covington	12	4	11	5
Oconee Valley W. H. Rhodes, Jr. Union Point	12	10	12	11
Walton R. M. Tankesley Monroe	7	5	7	5
Washington J. W. Traer Sandersville	10	3	9	3
Wilkes Sophia Bamford Washington	6	5	6	5
	190	127	199	138

COBB COUNTY MEDICAL SOCIETY COUNCILOR AND VICE COUNCILOR

Remer Y. Clark, M.D., Councilor and Charles R. Underwood, M.D., Vice Councilor

The increasing need for health care facilities in Cobb County continues to stimulate expansion of existing facilities and construction of new and separate ones. Kennestone Hospital is well into a major expansion with construction of an entirely new facility at an estimated cost of $20 million and a 650 bed capacity upon completion. Cobb General Hospital is also presently undergoing a major bed expansion having recently completed new emergency room facilities. In addition to these two public facilities, we have also had two private hospitals open in the last year.

Several members of the Cobb County Medical Society have been active in affairs of the Medical Association of Georgia. The local Society continues to be an active and an effective one with Gary Palmer, M.D. serving as president during the coming year. Cobb County members continued to represent the growing needs of the area with active participation in the Medical planning of Metropolitan Atlanta.

We continue to enjoy the benefits of a very active and well administered auxiliary. The gift shop at Kennestone Hospital is efficiently run and produces a profit which is quite helpful in maintaining an up-to-date Medical Library as well as establishing a reserve fund to be utilized for furnishing of the gift shop in the new hospital. The Annual Kennestone Hospital Ball is supported to maximal capacity by the community and thus provides good financial support to certain areas of the hospital. The Cobb County Symposium, now in its ninth year, continues to provide an annual meeting of great benefit to the community as well as to the Medical Society, Bar Society and clergy which support it.

We are in the midst of an active membership drive effectively being pursued by Dan Stephens, M.D. and aimed at increasing our membership in both the Medical Association of Georgia and the American Medical Association. The Cobb County Medical Society now has 209 members, of which there are 190 members of the Medical Association of Georgia with 185 of the 190 being members of the American Medical Association.

MEDICAL ASSOCIATION OF ATLANTA COUNCILORS

John T. Godwin, M.D.

The councilors have attended all meetings during the past year. The councilors have participated in additional meetings as indicated and appropriate. There are no specific suggests from the councilors and vice-councilors at this time.

FIFTH DISTRICT MEMBERSHIP

County and Secretary	Members December 31, 1972 MAG	Members December 31, 1972 AMA Dues Paying Only	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only
Medical Association of Atlanta R. Carter Davis, Jr. Atlanta Fleming L. Jolley Atlanta Councilor J. Harold Harrison Atlanta Councilor John T. Godwin Atlanta Councilor	1,194	924	1,196	923

MUSCOGEE COUNTY MEDICAL SOCIETY COUNCILOR

Jack A. Raines, M.D.

THIRD DISTRICT MEMBERSHIP

County and Secretary	Members December 31, 1972 MAG	Members December 31, 1972 AMA Dues Paying Only	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only
Muscogee Bob R. Maughon Columbus	173	124	170	124

RICHMOND COUNTY MEDICAL SOCIETY COUNCILOR

Ronald F. Galloway, M.D.

All meetings of council during the past year have been attended by me or my vice-councilor, Dr. Henry Scoggins. We have no specific recommendations to make to the House of Delegates this year.

TENTH DISTRICT MEMBERSHIP

County and Secretary	Members December 31, 1972 MAG	Members December 31, 1972 AMA Dues Paying Only	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only
Richmond				
Jimpsey B. Johnson				
Augusta	308	266	311	270

COMMITTEE ON PROFESSIONAL CONDUCT AND MEDICAL ETHICS

T. A. Sappington, M.D.

The Professional Conduct and Medical Ethics Committee has met on two occasions in the past year and discussed the problems brought to the Committee's attention. The attendance of the Committee members has not been as high as is desired at these meetings.

It is hoped that the Medical Association of Georgia will work closely with the State Composite Board of Medical Examiners in having effective investigation and action on cases of breaches in the professional conduct and medical ethics of the M.D.'s and D.O.'s licensed to practice medicine in Georgia.

COMMITTEE ON EMERGENCY MEDICAL SERVICES

Carl Jelenko, M.D.

The Committee met in the Conference Room of the Medical Association of Georgia on April 21, July 14, and October 27, 1973 and on January 19, 1974. Average attendance was 75 per cent of the members; and an average of six guests as well as staff present.

Major considerations of the Committee through the year comprised the following:

1. *Emergency Health Services Advisory Council (EHS) of the Department of Human Resources:* Five members of the MAG EMS Committee serve on the EHS Council (38 per cent). They are Mr. Glen Hogan and Drs. Luther M. Vinton, Robert Wells, Charles B. Gillespie (chairman) and Carl Jelenko, III (vice chairman). The Committee discussed—for advisement of the EHS Council—a system of priority assessment of counties for receipt of the Department of Transportation funding and funding available under the Emergency Medical Health Services Act of 1973. The system uses objective, readily obtainable data on each county to allow it to be priority listed by need. Additionally, Emergency Health Systems (Regions) have been defined and a method of priority-listing the systems and sub-assigning counties by priority into these systems was developed. The various concerns of the EHS Council were discussed from time to time.

2. *Legislation:* It was reported that the Governor had vetoed the Bill that would have provided a Medical Advisory Council for training medically "unqualified" individuals for driver's licenses. Later, such a committee was established within the Department of Highways. Considerable discussion was held over Public Law 37 which empowered Civil Defense to act in "any emergency or disaster." New wording was developed—and introduced into the 1974 Legislature—that would avoid any subversion of Good Samaritan provisions of various laws. During the legislative session of 1974 at least six bills were introduced which would have seriously deformed the ambulance and physician assistant regulations in the state. Primarily, these were introduced by a self-serving ambulance group; and all were prevented from reaching the floor.

3. *Emergency Medical Technician/Ambulance Training:* Two areas of concern were addressed by the Committee: a) the Committee reviewed several ad hoc training programs that had been offered—and completed—by highly qualified physician-trainers for Emergency Medical Technicians/Ambulance. All such programs were approved, however it was the decision of the Committee to deny future approval to programs that had not been reviewed prior to initiation of the respective courses; b) A program of training for all Emergency Medical Technicians/Ambulance in the use of radio communications and in the use of intravenous fluid and drug therapy under physician control was developed. This program was ultimately approved by the Emergency Health Unit and by the MAG Committee on Medical Practice and has been instituted as a required portion of the EMT courses being taught in the vocational-technical schools.

4. *Considerable discussion was held regarding the failure of the Hartsfield-Atlanta International Airport to develop a minimally acceptable disaster plan:* The Committee looked at this problem from a variety of angles and at present has allowed the Atlanta Regional Council through Metro Emergency Medical Systems, Inc. (MEMS—the new five county CHP-B Agency) to negotiate with the Airport Authority in this matter. Despite the effects of MAG pursuant its resolution from the 1972 General Convention, no progress has been effected in this matter! The Hartsfield-Atlanta International Airport continues to be one of the world's busiest facilities and to have an abominable and reprehensible position with regard to reasonable planning for human casualties in the event of a disaster or mass casualty situation anywhere on airport grounds! The Committee wonders about the propriety and utility of involving the media in this problem.

5. *A variety of topics were discussed at one or more of the meetings:* These include the establishment of the "MAST" (Military Assistance to Safety and Traffic) Program in Georgia. The program provides military helicopters for evacuation of emergency patients to appropriate hospitals. Categorization of hospitals was reviewed and updated. Through the medium of evaluating ambulance trip reports, a trauma registry will be developed in the state. Some discussion of the role of medicine in disaster planning was held attending the tornado damage to Athens, Georgia. Members of that community participated in these discussions. Dr. Jolley reviewed plans to train driver's license examiners in visual screening. The Committee participated in the 3rd Annual Flame-Free Design Conference held at the

Marriott Motor Hotel in March of 1974 and had members on the Local Arrangements Committee.

FUTURE DIRECTIONS

Three or four items are the subject of continuing work. These include continued participation in and cooperation with the Emergency Health Services Advisory Council in the development of a regionalized system of emergency care in the State of Georgia. Work has begun in developing a program for requalifying and re-examining Emergency Medical Technicians. Work continues aimed at developing an emergency program at the Hartsfield-Atlanta International Airport. The Committee is interested in helping to develop, in cooperation with the Georgia Conservancy, a program for legislating appropriately for the use of glass soft drink bottles as has been successfully concluded in Oregon. In addition, the Committee developed a statement of purpose (see attachment). No recommendations are offered to the House of Delegates unless it wishes to take further action in the Airport matter.

STATEMENT OF MISSION EMERGENCY MEDICAL SERVICES COMMITTEE

The early history of the Emergency Medical Services (EMS) Committee comprises the fact that this committee was a composite representing unification of the previous Disaster Planning Committee and Highway Safety Committee. The functions of both of the former committees therefore became the mission of the new EMS Committee which has expanded, by necessity, its concerns, scope, and mission.

The basic mission of the Committee is to work with the physicians of the State of Georgia and with all other agencies concerned with the delivery of Emergency Health Services to develop a logical, systematized, medically sound Emergency Health Services delivery system in Georgia.

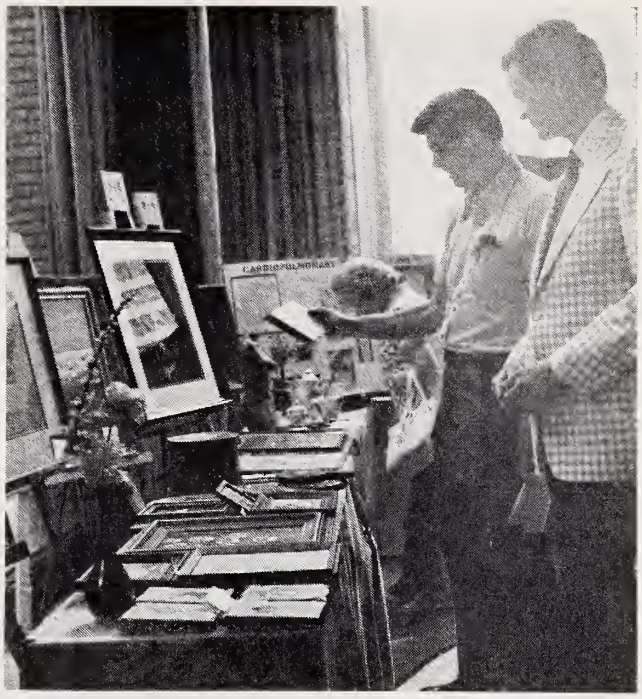
The committee has met these goals by expanding to include among its advisory members representatives from the American College of Surgeons Committee on Trauma, the Emergency Health Unit of the Division of Physical Health of the Department of Human Resources, Georgia Regional Medical Programs, selected ambulance service providers, Georgia State Civil Defense, and other ad hoc advisors.

Activities have—and will—encompass:

a. Planning efforts: investigating the needs of the state in terms of emergency medical services within the purview of the scope of Medical Association of Georgia and devising methodology appropriate for solving these problems.

b. Legislative efforts: designing, developing and attempting to influence the course of primary and enabling legislation which directly affects the delivery and/or funding of emergency medical service projects.

c. Education and training: physician and paramedical personnel education in emergency health care delivery including physician assistants, emergency medical technicians/ambulance, and intravenous solution and drug administration are examples of the areas of interests in this category. In addition physician advisors and the educational requirements and certifications and recertifications devolving from the physician assistant and emergency medical technician sectors have been, and will continue to be, major concerns.



Displays of special projects, art work and scrapbooks by Auxiliary societies are admired by delegates Keith Quarterman and Douglass Whitney of Atlanta.

d. Disaster planning: the Committee has developed and published a generic plan for emergency preparedness/mass casualty planning and continues efforts to maintain the quality of this program.

e. Emergency Medical Technician/Ambulance Certification: the Committee has been designated by the Emergency Health Unit of the Department of Human Resources to study the faculty and curricula of various EMT/A programs and to recommend approval (by the State of Georgia) of these programs

f. The Emergency Health Services Advisory Council to the Board of Human Resources: the Committee maintains close liaison with this group and through the Committee's chairman (who is the vice-chairman of the EHS Council) and a Committee member (who is the chairman of that body) attempts to represent on continuing basis the position of MAG with regard to the Advisory Council's goals and activities.

g. Miscellaneous: the Committee has worked at developing an emergency medical services plan for the Hartsfield-Atlanta International Airport; to develop a MAST system for Georgia, to modify by appropriate legislative action certain of the laws in apparent conflict with safe and secure practice of medicine (i.e., Civil Defense Law PL37 [H.B. 385, 1973]); to maintain an up-to-date categorization list of hospitals; support appropriate conferences (i.e., the Flame-Free Design Conference); to develop and extend the use of the Emergency phone number 911 throughout the state.

The Committee views as its on-going mission the appropriate development of systematized, regionalized, reasonably funded Emergency Health Systems for Georgia using the cooperative efforts of those organizations involved in this activity.

It has been found expedient from time to time to combine the meetings of the Emergency Medical Services Committee with those of the American College

of Surgeons Committee on Trauma for Georgia since the memberships overlap and the goals are identical.

COMMITTEE ON CANCER

Hoke Wammock, M.D.

In January of 1973 the Committee on Cancer was informed through the Physical Health Division of the Georgia Department of Human Resources that some $34 million would be available for cancer control for the various states. From this point on we developed a series of meetings for the purposes of developing a Statewide Cancer Control Program and to procure adequate funding of this program through the National Cancer Institute. It was obvious that the Regional Medical Program would be phased out as of December 31, 1973, and furthermore, the funds from the State-Aid Cancer Control Program for the past 10 years had been in the neighborhood of $400,000 to $500,000 and FY 1972-1973 were $400,000. These were inadequate to cope with the problem of cancer control in Georgia. Beginning in April 1973, the Committee on Cancer of MAG began groundwork for the development of a Cancer Management Network Program for the State of Georgia. The Network would preserve intact and build on the achievements of the Georgia Regional Medical Program to insure that the best possible care for cancer patients is available to patients throughout the state.

At a meeting in June of 1973 we invited representatives from the Division of Physical Health of the Georgia Department of Human Resources, the Georgia Regional Medical Program, the Georgia Division of the American Cancer Society, the Medical College of Georgia, Emory University School of Medicine, and other agencies and groups or individuals concerned with cancer control.

At this meeting we considered and approved an outline of the goals, functions and organizations of a Cancer Management Network Program for the State of Georgia, and an outline of this Program was printed in the August 1973 *Journal of the Medical Association of Georgia* in an article by Charles Huguley, M.D.

This group agreed that our next step was to begin organizing a Network Advisory Council to draw up a Charter establishing the Cancer Network Program. This Advisory Council would include the above representatives as well as other hospitals and cancer facilities not supported by GRMP or the State-Aid Cancer Control Program. For the sake of brevity only a few of the representatives are mentioned here: namely, the Georgia Hospital Association, the Veterans Administration Hospitals, representatives from the Georgia Academy of Family Physicians, the American College of Surgeons, representatives from Medicare and Medicaid, Blue Shield and Blue Cross, and third party carriers. In addition to this, there would be lay representatives from various communities. This Advisory Council would, therefore, be composed of some 70 members.

From this meeting was appointed an Ad Hoc Committee which was charged with the responsibilities of preparing a network organizational structure. Members of this Ad Hoc Committee are:

Hoke Wammock, M.D., representing MAG
J. Gordon Barrow, M.D., GRMP
Joseph A. Wilber, M.D., Human Resources
John P. Wilson, M.D., American Cancer Society
Herbert E. Brizel, M.D., Medical College of Georgia
Charles M. Huguley, Jr., M.D., Emory University School of Medicine

On July 19, 1973, the Georgia Regional Medical Program hosted the first meeting of the Ad Hoc Committee. Dr. Charles M. Huguley was elected permanent chairman.

On September 6, 1973, the second meeting of the Ad Hoc Committee met and had a lengthy discussion regarding the Cancer Control Program of the National Cancer Institute and the type of projects that they were interested in supporting as we were in dire need of financial support to continue our ongoing Statewide Cancer Control Program.

On October 4, 1973, the Ad Hoc Committee again met at which time action was taken to the effect that this Committee would prepare a budget requesting an interim grant from the National Cancer Institute from January 1, 1974 to June 30, 1974. This would give us an opportunity to prepare for a continuation grant for FY 1974-1977. The purpose here was to tide us over for the first six months of 1974 until we could make a request for a continuation grant for three years.

On November 15, 1973, the Committee met again to consider three major items:

1. Bylaws of the Cancer Management Network Program.
2. A proposal for interim support of the existing GRMP area cancer facilities and registry programs.
3. To request the Medical Association of Georgia to serve as the fiscal agent for the interim period and also to serve for the continuation of the Program in the event that the grant was approved by the National Cancer Institute.

Following this meeting of November 15, a proposal was made to the National Cancer Institute for an interim support from January 1, 1974 until June 30, 1974. Unfortunately, this grant was not approved because the program of the National Cancer Institute for statewide programs had been altered and support would only be available in certain categories:

1. Breast cancer
2. Head and neck cancer

In view of the change of the concept of the National Cancer Institute for cancer control, a proposal was filed by the Ad Hoc Committee on January 14, 1974, for a "Prototype Network Demonstration Project in Breast Cancer." On January 29, 1974, a second proposal was filed, "Prototype Comprehensive Network Demonstration Project for Head and Neck Cancer." As of this moment we have not received any information regarding the disapproval or approval of these grants.

The action taken by the National Cancer Institute on these grants will be made a part of the addendum to this report when we receive information from the NCI as to the action taken on the proposed grants.

On January 24, 1974, a meeting was held with the members of the Ad Hoc Committee and the Advisory Council, and at this time, a draft of the constitution and Bylaws was adopted.

Next was the selection of a nominating committee for the election of permanent officers of the organiza-

tion. The results of a nominating committee will be submitted at a later date.

Following the meeting on January 24, 1974, the Cancer State-Aid Program was reviewed in depth with Joe Wilber, M.D. with the hopes that we would be able to procure increased funds for the State-Aid Cancer Control Program. The funds for the Cancer State-Aid Program for the past 10 years have been in the neighborhood of from $400,000 to $500,000 and for 1974-1975 $440,000 will be available.

On October 4, 1973, Governor Jimmy Carter held a meeting titled "Killers and Cripplers" at which he presented his Health Control Program for the State of Georgia. In this budget in addition to the $440,000 for the State-Aid Cancer Control Program was an additional $763,636 to carry out a more comprehensive Cancer Program in Georgia, but unfortunately the budget of the Governor has met with considerable resistance and it appears as of this moment that we will have only $440,000 for Cancer Control in the State of Georgia FY 1974-1975 for the State-Aid Cancer Control Program.

Funds for the Georgia Regional Medical Program were impounded by the President and this program was to have ended December 31, 1973, but by action of the Federal courts these funds have been restored. As a result of this, the Committee on Cancer met with representatives of the GRMP Program, the American Cancer Society, Georgia Division, and the Division of Physical Health of the Department of Human Resources to review the Regional Medical Program as related to cancer in Georgia and to update the program as to the type to be conducted and funded.

It was pointed out at this meeting that the funding for the Cancer State-Aid Program was totally inadequate and we should bring to the attention of the members of the Legislative and Executive body of the need for greater support.

In view of the fact that the National Cancer Institute had altered its support for a Statewide Cancer Management Program as indicated above, we have filed requests for support of a Breast Cancer Program and for a Head and Neck Program. As this report is being prepared, we have not received any information from the National Cancer Institute as to whether or not these projects will or will not be approved.

As Chairman of the Committee on Cancer, I can only say that your Committee on Cancer has worked long and hard in a cooperative spirit in every way possible with the Georgia Division of the American Cancer Society, the Georgia Regional Medical Program, the Division of Physical Health of the Georgia Department of Human Resources and with the two medical schools and others in an effort to design and develop a Cancer Management Network Program for the State of Georgia for research, education, service, and epidemiology in cancer control.

As previously indicated above, we have requested the Medical Association of Georgia to serve as fiscal agent for these two projects in the event that they are approved by the National Cancer Institute.

We have developed a statewide Advisory Cancer Council with the hopes that we can develop a more comprehensive Cancer Control Program in Georgia.

With the release of funds by the Federal Government for the National Regional Medical Program and the possibility that we may receive funds for two projects, one in breast cancer and one in head and neck cancer, let's hope that the program will be a little brighter than what I have reported.

There is also a need to properly inform the legislative and the executive body of the State of Georgia of adequate funding for cancer control in Georgia.

INSURANCE AND ECONOMICS COMMITTEE

William W. Moore, Jr., M.D.

The Insurance and Economics Committee has been quite active in the 1973-1974 fiscal year.

First, and most important, 112 professional liability claims have been received by St. Paul this year (1973) which is more than double the number received in 1972, and some of the claims are quite large. Needless to say, we must all be more attentive and careful if we are to keep our professional liability premiums from rising.

Secondly, the Committee recommended, and Council approved, the transfer of our group life, major hospital and disability insurance from the Life of Georgia to the Southern Medical Association Plan, which is insured by Connecticut General Insurance Company. Southern Medical took over all of our members enrolled in the Life of Georgia Plan, and we feel that we now offer more protection for your premium dollar than any group plan we have seen.

The transfer from one plan to another was very orderly, with just a few problems, and the Committee wishes to express its appreciation to both companies for their great cooperation.

St. Paul is now sending each of the physicians it insures a bimonthly brochure relative to the better ways to prevent professional liability claims. Please, take time to read these brochures—then resolve that we will do our best to cut the number of claims for 1974 by at least 50 per cent.

COMMITTEE ON NATIONAL LEGISLATION

Harrison L. Rogers, M.D.

On the national level there are 1,200 Senate and House bills introduced pertaining to different areas of interest to physicians. Several bills of importance are discussed separately as follows:

NATIONAL HEALTH INSURANCE—As of this date the AMA Medicredit Bill, H.R. 2222, S. 444, has more sponsors (183) than any other national health legislation. Several members of the Georgia delegation are among the 183 co-sponsors of H.R. 2222. This topic is one all of you are vaguely familiar with and have heard and read many thoughts about in the past. Most officials in Washington agree that there will be no national health insurance bill passed during the 1974 session of Congress. However, there will be legislation of this type voted on during the 1975 Congress. During this time there is an election year; there will be new and different Congressmen with different ideas to be considered during 1975. It is of vital concern to the AMA, the MAG and all physicians in Georgia to familiarize themselves with Congressional candidates and seek a winner in their districts and one that will sup-

port medicine and the national health insurance bill among others.

H.R. 2222 (the Medicredit Bill) is designed to give maximum help to those unable to help themselves and minimum help to those able to pay their own way. To accommodate the people between these two extremes, a sliding scale, based on the amount of income tax paid, is used to determine the amount of federal help one would receive.

It will pay a percentage of the cost based on the amount of income tax the family or individual owes. As income goes up, the federal contribution comes down.

MAG House of Delegates endorsed the concept of Medicredit at its meeting in 1972 as being the most logical answer to the health insurance matter.

It is also felt by many that the Medicredit Bill would be less expensive by tens of millions of dollars than any other of the proposed national health insurance bills; this being reflected to you as taxpayers in a smaller increase in taxes.

NATIONAL HEALTH POLICY AND HEALTH DEVELOPMENT ACT OF 1974 H.R. 12053—Your National Legislative Committee along with many MAG members and many staff members of AMA think H.R. 12053, if passed in its original form, would be more devastating than PSRO or any other national bill concerning physicians that has been introduced in the past several years.

The bill would have Congress find that 1) equal access for all to reasonable cost, high quality medical care is a federal government priority; 2) the recent massive infusion of federal funds in the existing health care system has produced neither an adequate supply nor an adequate distribution of health care resources, and thus has not made possible equal access to health care resources by the total population; 3) public and private sector cooperation has not developed effectively a rational comprehensive approach to the problems of the lack of effective health care delivery and the maldistribution of health care facilities and manpower.

The bill would have Congress find that priority consideration, in national health policy formulation, and any development and operation of national and local health planning, development, and regulatory programs, should be given to: 1) a provision of primary care services for medically underserved populations especially those which are located in rural or economically depressed areas; 2) development of multi-institutional systems for coordination or consolidation of institutional health services (including obstetric, pediatric, emergency medical, intensive and coronary care, and radiation therapy services); 3) the development of medical group practices, especially those with services appropriately coordinated or integrated with institutional health services; 4) the training and increased utilization of physicians' assistants, especially nurse clinicians; 5) development of multi-institutional arrangements for the sharing of support services necessary to all health service institutions; 6) the promotion of activities to achieve needed improvements in the quality of health services, including needs identified by the review activities of Professional Standards Review Organizations; 7) development by health service institutions of the capacity to provide various levels of care (including intensive care, acute general care, and extended care) on a geographically integrated basis; 8) the adoption of uniform cost accounting, simplified reimbursement and utilization in reporting systems and improved management procedures for health service institutions; 9) the development of effective methods for financing of, reimbursement for and regular rates of reimbursement and payment for medical care.

As you can see, this is a very extensive bill which is in no way even briefly covered in the above two paragraphs. Two major repercussions from this bill would be federal licensure of all physicians and cost regulations set for physicians and hospitals by the federal government. An application of the above two items in order to practice medicine in Georgia, not only would you have to have a Georgia license but also a federal license thus giving the federal government an opportunity to regulate where one practices. Secondly, the federal government would have the authority to set fee scales for physicians, hospitals, nursing homes, etc.

The administration—President Nixon—is expected to introduce a bill to replace H.R. 12053 which was introduced by Congressman Rogers from Florida. If the administration bill is introduced, it will be thoroughly analyzed by your Committee on National Legislation and a summary will be sent to all members on this vital legislation.

PSRO—The enactment of the PSRO provision of H.R. 1 is evident and is occurring. As you are probably already aware, Georgia has been delegated as one PSRO area and in the near future guidelines will be set up to enact this PSRO. However, to date 21 bills have been introduced in either the House or the Senate to repeal the PSRO provision under H.R. 1.

CHIROPRACTIC—The Bureau of Motor Carrier Safety, a department of the federal government in Washington, was considering the use of chiropractors to perform required periodic medical examinations on drivers of commercial vehicles. A notice of this was published in the *Federal Register* February 28 of last year requesting interested parties to make comment. Your Committee, along with 273 other interested parties throughout the United States, commented in response to this proposal. Commenting on the proposal, they stated that it would be "extremely dangerous" to permit chiropractors to perform these physicals and that alteration of long established rules could lead to "other health cults" requesting some of the privileges and "similar requests to examine others engaged in interstate commerce, such as airplane pilots." The result of the efforts of MAG and your Committee, along with the other states, was reversal of the opinion of the Bureau of Motor Carrier Safety, therefore not permitting chiropractors to perform the physical examinations of motor carriers.

ANNUAL CONGRESSIONAL LUNCHEON—1974 Annual Congressional Luncheon was held on March 15 in Washington. As in the past, each member of the Georgia delegation from the House and Senate was invited to attend our luncheon and each was hosted personally by a physician constituent. The majority of the House delegation was present. Those not attending had previous commitments and were out of the state as were both Georgia senators, Talmadge and Nunn. All Congressmen and Senators who were not in attendance were represented by a member of their staff. It is felt by your Committee that this luncheon serves as a very

vital link between the physicians back home and our Congressmen and Senators in Washington.

COMMITTEE ON STATE LEGISLATION

Harrison L. Rogers, M.D.

The following is a summary of 34 of the 92 pieces of legislation of interest to the Medical Association of Georgia considered during the 1974 session of the General Assembly:

BILLS PASSED DURING THE 1974 SESSION

Newborn Insurance Coverage (H.B. 995): MAG supported. Bill prohibits insurance companies that write newborn coverage from excluding the first 14 days of life; therefore, for all policies that include newborn coverage, this coverage would begin at the moment of birth.

Maternal Health Council (S.B. 649): MAG supported. Expands the Maternal Health Council to include the same number of pediatricians as obstetricians.

Speech Pathology and Audiology (H.B. 1342): MAG supported. The bill would create a Board of Examiners for Speech Pathology and Audiology to regulate practices of both. DeKalb County Medical Society, Representative Robin Harris and others put much work on this bill last summer and helped tremendously in seeking its passage.

Hospital Authority—to Clarify Meaning of Term "Project" (H.B. 1419): MAG supported. This bill adds to the definition of the word "project" doctors' buildings. Therefore, definition of the word "project" under the hospital authority includes the "acquisition, construction and equipping of hospitals, sanitariums, dormitories, office buildings, clinics, *doctors' buildings*, housing accommodations, nursing homes, rehabilitation centers, extended care facilities and other public health facilities for use of patients and employees." One effect of this is that all property owned by a hospital authority is public property so as to be exempt from ad valorem taxation.

Civil Defense Act—Good Samaritan Law (H.B. 1507): MAG supported. A bill passed the Georgia Legislature in 1973 that by some interpretations was in direct conflict with the very good Georgia Good Samaritan Law. H.B. 1507 simply repeals that part of the law passed last year to keep Georgia's Good Samaritan Law intact.

Georgia Anatomical Gift Act—Donor's Death (H.B. 1560): MAG supported. This bill requires the Department of Public Safety to provide forms for the gift of all or part of a person's body conditioned upon the death of the donor to appear on the donor's driver's license.

Common Day of Rest, Set Aside One Day—Conducting Business (H.B. 974): This bill would limit the conducting of business on one of the two consecutive days of Saturday and Sunday. As originally introduced the bill excluded hospitals and nursing homes but had no clause to exclude physicians who practice in their office or physicians making house calls, etc. Amendments were made so that physicians could practice at will on Saturday and Sunday as they have always done in the past. Except for other groups that were also excluded, all businesses have to close for one 24-hour period from midnight Friday night to midnight Sunday night.

Alcoholism and Intoxication Treatment Centers (S.B. 330): MAG supported. This bill, introduced in 1973, underwent numerous changes during the summer and the 1974 Legislature. Much was added by the Medical Association of Atlanta with cooperation of the MAG Committee on Mental Health. Briefly summarizing this 24 page bill, the state would appropriate money to build alcoholic treatment centers. Once these centers are built, instead of alcoholics being arrested and taken to jail for public drunkenness, acquiring a police record, they would be taken to alcoholic treatment centers and given proper medical treatment.

Uniform Narcotic Drug Act (S.B. 495): MAG supported. S.B. 495 is a 50 page bill which updates all controlled substances and reclassifies Schedules I, II, III, IV and V drugs. It allows the Board of Pharmacy to administer all parts of this law or reschedule all substances in this chapter pursuant to the Georgia Administrative Procedure Act. S.B. 495 further sets out classification of act in terms of punishment for violations according to the act or the schedule in which the controlled substance is listed. This bill goes into much more depth than space permits here. If anyone wishes a copy of the bill and a summary of the bill, please notify MAG Headquarters.

Medical Practice Act (S.B. 612): MAG supported. This bill amends the existing Medical Practice Act. S.B. 612 was sponsored by the Composite State Board of Medical Examiners. In essence, these amendments would:

1. authorize the Board to carry out investigations either by itself or through the Joint Secretary and to employ a permanent staff of investigators if needed;
2. change the requirement that regular meetings for examinations be held in Atlanta and Augusta and would leave meetings to the Board's discretion;
3. authorize the Board to ask specific questions about a physician's qualifications to practice medicine each year when he applies for a license renewal;
4. redefine the grounds upon which a physician may be disciplined and the procedures to be followed by the Board in doing so;
5. after a physician has violated a provision, allow the Board to (a) refuse to license an applicant, (b) issue a private or public reprimand to the physician, (c) suspend a license for a set period, (d) restrict a license, (e) revoke a license, (f) condition or withhold doing any of these things if a physician will submit himself to professional care;
6. permit the Board to reissue a license which it has previously revoked under either present or antecedent law;
7. give the Joint Secretary the power to start investigations concerning a physician if a district attorney believes there may be some wrongdoing;
8. permit any record a physician may have made in regard to a patient be admissible to the Board in a hearing to determine the physician's fitness to practice medicine;
9. empower the Board to issue a provisional license to an applicant, otherwise qualified, but before passing the required examination, allowing him to practice medicine only in an area the Board determines to have a shortage of doctors.

The original version of S.B. 612 contained two controversial sections dealing with nurses. These sections were deleted at MAG's request to be further studied during the summer months.

Pharmacists, Pharmacy and Drugs, Information on Prescriptions (S.B. 613): MAG supported. This bill clarifies who can write a prescription for drugs in Georgia. They are "physicians, dentists, veterinarians or any other person directly authorized by statute to prescribe drugs" (podiatrists) "in connection with medical treatment to the extent provided by the laws of the state." No person other than a practitioner of the healing arts may prescribe a dangerous drug. Practitioner being defined as physician, dentist, veterinarian or podiatrist.

Nursing Home Certificate of Need (S.B. 16): This bill introduced last year passed the House of Representatives in an amended form to include both nursing homes and hospitals. During the '74 session this bill was changed back to its original form as introduced by the Georgia Nursing Home Association. S.B. 16 sets up a board to review applications and to issue a certificate of need for any expansion or new construction of nursing homes in Georgia.

Dental Surgeon Insurance Coverage (S.B. 153): This bill also introduced during the 1973 session did not pass last year, and after careful study and scrutiny by MAG and its attorney, we felt this bill, if not amended, would not infringe upon the breach of contract theory of insurance coverage which MAG has long supported.

Before a vote on this bill came during this session of the House of Representatives, an unsuccessful attempt by chiropractors to attach an amendment including themselves was attempted. After this amendment was overwhelmingly defeated, the bill passed. If signed by the governor, it would permit dental surgeons to be paid by insurance companies for their oral surgery work the same as physicians.

Public Health Study Committee (S.R. 300): MAG supported. This resolution authorized the governor to appoint ten members to a committee to study state laws relating to public health and to prepare legislation necessary to compile, clarify and codify state laws relating to public health. Composition of this committee will include members of the Senate, members of the House of Representatives, a member of the Georgia Public Health Physicians Association, a representative of MAG and others appointed by the governor at large.

Professional Standards Review Organization (S.R. 301): MAG supported. This resolution passed both the House and the Senate without one dissenting vote. S.R. 301 authorizes and directs the Secretary of State to transmit a copy of this resolution to the Secretary of the Senate of the United States, to the Clerk of the House of Representatives of the United States and to each member of the Georgia Congressional delegation. The resolution requests Congress to repeal the Professional Standards Review Organization Law as quickly as possible to prevent the damage it will cause to the public and to the American health care system.

BILLS DEFEATED DURING THE 1974 SESSION

Health and Welfare Merger (H.B. 360): MAG opposed. This bill passed the House of Representatives during the 1973 session, was studied extensively by the Senate EREG Committee during the summer and was voted down by a vote of 9 to 2 in Committee during the first week of the 1974 session. This bill was an attempt to consolidate on a county level the county Health and Welfare boards.

Certificate of Need (H.B. 504): MAG opposed. This bill passed the House of Representatives during the 1973 session, was studied by the Senate Health and Welfare Committee during the interim and was voted down overwhelmingly by the Senate committee during the 1974 session. This bill, if passed, would have set up a system whereby the Board of Human Resources would have the authority to say where and by whom every hospital in Georgia could be built. This, in effect, is contradictory to the freedom of choice concept upon which Georgia has long thrived.

Acupuncture (H.B. 1360): MAG was neither in favor nor against this bill but felt it was an attempt to pass legislation that was unnecessary. The bill simply restated what the Attorney General has already ruled—that anyone puncturing the skin would be practicing medicine and therefore subject to a misdemeanor for practicing medicine without a license. Therefore, dentists and physicians can use acupuncture at their discretion under the current ruling of the Attorney General of Georgia.

Maternity Care Insurance Coverage (H.B. 1362): MAG supported this bill in concept but felt it was almost impossible to pass. This bill would mandate each and every health insurance contract written in Georgia to include the maternity care package, this covering the mother from point of conception until dismissal from hospital. Many insurance companies offer this coverage today; the estimated cost per policy for this coverage is not known but could conceivably run into many dollars per policy per month.

Abortion (H.B. 1442): This was another unsuccessful attempt by the Georgia Right for Life group not only to alter the existing abortion laws in Georgia but to make them contrary to the Supreme Court ruling regarding abortion. MAG opposed this bill and sought its defeat. Therefore, the abortion law in Georgia remains the same as passed in the 1973 session, sponsored by MAG, which simply states that during the first trimester all abortions have to be performed by a licensed physician in Georgia. During the second trimester all abortions have to be performed by a licensed physician in a licensed clinic or hospital. During the third trimester all abortions have to be performed by a physician with a concurrence of two consulting physicians that said abortion is for the best health of the mother.

Optometry Freedom of Choice (H.B. 1805): MAG opposed. This bill would prohibit anyone from discriminating against optometrists in regard to treatment of the eye. MAG, along with the Georgia Ophthalmology Society, vigorously opposed this legislation for a number of reasons. Under Georgia law optometrists are only licensed to fit refracted lenses and are not licensed, trained or qualified to diagnose or treat eye diseases. If this bill had passed, it would not give them authority to treat eye diseases but would give them an opportunity to do so without proper referrals to M.D.'s. Through the efforts of ophthalmologists throughout Georgia, with the assistance of many interested MAG members, contact was made both personally and by phone with all members of the Senate and Lieutenant

Governor Maddox seeking defeat of H.B. 1805. This bill passed the House of Representatives and passed the Senate Health and Welfare Committee but was never called for a vote in the Senate and in essence was defeated this year.

County Health Board (H.B. 1809): This is a very short, one page version of House Bill 360 mentioned earlier which would authorize and direct county boards of health, county boards of family and children's services, and their respective departments to take the necessary action to insure full and complete cooperation between all county departments. MAG opposed this bill as they did H.B. 360 and sought its defeat.

Psychology Insurance (H.B. 2001): MAG opposed. This was another bill which would breach an individual's right of contract as far as insurance policies go, very similar to that which the chiropractors tried last year, which would mandate psychologists be covered on all health and accident insurance policies. Like the chiropractic bill, H.B. 2001 was defeated.

Ambulance Legislation (H.B. 1608, 1761, 1811, S.B. 568, S.R. 299): All five of these pieces of legislation were defeated this year. All had to do with the Georgia Ambulance Service Act, emergency services, etc. to alter the present existing law in some form or fashion. The MAG Legislative Committee along with MAG Rural Health Committee felt that these bills would greatly hinder the good programs that have been set up in the past. Therefore, our position was against these bills, and fortunately, none passed this session.

State Hospital Administrator (S.B. 222): MAG supported this bill which would *reclarify* existing Georgia law and would specifically state that the superintendent or administrator of any state operated mental institution would have to be a physician. Governor Carter had stated that if this bill passed, it would be vetoed, but still this bill passed the Senate and through much deliberation, confusion, excitement and controversy, was defeated in the House Health and Ecology Committee. Let me restate, however, current existing law which is under study by the Attorney General's office today states that the superintendent of all mental hospitals has to be a doctor of medicine.

Reinstatement of Medical License—Criminal Conviction (S.B. 427): MAG opposed this bill which stated that after a medical license had been revoked as a result of the holder's being convicted of a felony, the license could not be reinstated by the Board of Medical Examiners at any time. MAG felt that if a license was revoked due to a felony and said individual went through a rehabilitative process, then if the Board deemed fit to reinstate his license, it should be done.

Revocation of Medical License (S.B. 546): This bill is similar to S.B. 427 previously referred to. However, S.B. 546 requires refusal or revocation of license upon second conviction of a felony. This bill was defeated due to the penalty clauses and the amendments to the Medical Practice Act previously mentioned in S.B. 612. However, had this bill passed, it would have put the State Board of Medical Examiners as the direct agent to the Georgia General Assembly in acting on every bill passed by the Legislature.

Narcotic Drug Prescription—Physical Examination Required (S.B. 547): As this bill was originally introduced, it stated no physician could dispense or write a prescription for narcotic drugs without giving a patient a physical examination. MAG opposed this bill in its original state and suggested amendments to it which were a required physical examination within the previous five years and only if relating to Class II narcotics. With these amendments the bill was more acceptable but was still not preferred. This bill passed the Senate but failed overwhelmingly in the House of Representatives.

Hypnotism (H.B. 370): This bill was introduced as part of MAG's packet during the 1973 Legislature when it passed the House of Representatives and was being studied in the Senate Institutions and Mental Health Committee. Early in the session this year there was a hearing on this bill and it passed out of the Committee but was later recommitted at the request of several Senators. It was never reported out again, thus was defeated. MAG will try again in 1975 to pass a similar bill to H.B. 370 which states that only physicians and dentists may use hypnotism in their respective practices.

COMMITTEE ON MEDICINE AND RELIGION

Winford H. Pool, Jr., M.D.

The Medicine and Religion Committee was developed as an outgrowth of the similar department of the AMA. Its purpose is to address those concerns of medicine in which the clergy also have interest so that they may be studied together. Some of its functions are:

1. Promoting liaison between physicians and clergy as related to the treating of total patients.
2. Helping the establishment of chaplaincy programs in hospital settings.
3. Support meetings between the clergy with the medical staff of community hospitals on a continuing basis, so that mutual concerns may be discussed openly. Both areas of problems as well as the areas of new information should be included.
4. The establishment of seminars geared toward promoting better understanding of some of the basic problems of medicine in which the clergy have a vital interest, such as: (a) Abortion, (b) Death and Dying, (c) Euthanasia, (d) Drugs, (e) Human sexuality, etc.
5. Promote the use of these topics at county medical society meetings and help in providing program material as well as speakers for such meetings. Help establish medicine and religion committees in some county medical societies.
6. Sponsor a Medicine and Religion Breakfast at the annual MAG Meetings.
7. Promote liaison between faculties of schools of medicine and divinity.

The AMA Department also encourages through the state committees other activities. The work between medical schools and divinity schools in developing curricula of both the schools of divinity concerning various aspects of pastoral care related to hospitals and in schools of medicine places in the curricula where these problems can be discussed by both medical men and the clergy.

The fact that a medical association has a Committee on Medicine and Religion which is geared to addressing those problems in medicine that are becoming more numerous and more complex has in addition to the advantages listed, the fringe benefits of public rela-

tions. Here is a completely "unselfish" committee working toward the battle of patients in a very altruistic way.

The department is supporting the authorship of a book that will be geared toward medical students and interested physicians.

At the regional meetings, chairmen of the state committee are able to share with one another ideas that have worked in their areas as well as various programs that are available.

The committee in Georgia has engaged to some degree in most of these activities and it is hoped that in the future that participation in greater depth of these worthwhile methods can be accomplished, but new ideas will be forthcoming.

During the last MAG Annual meeting the Medicine and Religion Committee sponsored a prayer breakfast. Assistance in developing and presenting the program was provided by the Department of Humanities at the Medical College of Georgia. Rev. J. B. Rabun, and the Chairman attended the Southeastern Regional Meeting of State Medicine and Religion Chairmen, which was held in Atlanta during February of 1974.

COMMITTEE ON MENTAL HEALTH

William S. Davis, M.D.

In 1973 the Mental Health Committee has functioned primarily in an advisory capacity in matters of legislation which concerned Mental Health. This has been a year marked by many ups and downs in mental health as the new state division of the Department of Human Resources was still very much in the process of trying to set up comprehensive mental health care all over the state. Rumors and facts were flying with almost equal facility and a spirit of unrest prevailed generally.

The committee has been involved in legislative matters which included a number of bills to establish comprehensive treatment programs for alcoholism, a proposal to enable psychologists to receive payment directly from insurance carriers, Senate Bill 222 which provides that the administrator of a Mental Health Facility must be a physician, and bills which related to minor changes in medical hospitalization procedure.

The chairman of the committee met with representatives from the states of Alabama, North Carolina, South Carolina, Tennessee and Kentucky to lay ground work and make preliminary plans to hold the AMA's Regional Mental Health Conference in April 1974.

COMMITTEE ON OCCUPATIONAL HEALTH

Tom Howell, M.D.

The Occupational Health Committee has been primarily involved in absorbing the multitude of data from the National Institute of Occupational Safety and Health. Fourteen criteria documents have been submitted; these include noise, heat stress, asbestos, etc. Within the year of 1974, 24 more criteria documents are scheduled to be submitted to the Secretary of Labor.

The Occupational Safety and Health Committee has been utilized as consultants to the Governor's Committee on Workmen's Compensation. As of the date of this report, no definite Workmen's Compensation Bills have been passed in this session of the Legislature. Apparently, Georgia will not elect to accept the responsibility of state control of Occupational Safety and Health Act.

The Committee has no specific recommendations for consideration by the House.

PEER REVIEW COMMITTEE

John R. McCain, M.D.

The Peer Review Committee proposes that it continue its responsibility in functioning as the final level of the peer review appeals mechanism. (It is understood that appeal is available from the Peer Review Committee to the MAG Executive Committee of Council, but that such an appeal covers only an evaluation of the procedure followed and not of the substance of the review.)

The process of the Peer Review of medical care in Georgia has been clarified. The relation of the individual physician to the Georgia Medical Care Foundation and to the Peer Review Committee of the Medical Association of Georgia has been coordinated. A "flow sheet" has been prepared which describes the procedures involved. (The flow sheet itself is attached as Appendix A.)

The following information is provided to clarify the provisions of the flow sheet:

1. The Foundation is to coordinate the administrative aspects of peer review.
2. The criteria for review are to be developed by the specialty societies.
3. The consultants and the specialty panels will be coordinated by the Foundation.
4. The Peer Review Committee of MAG will provide:

a. The development of medical policy for review as described in the flow sheet. (1) The Preparation of a Policy Manual for Medical Care Review. (2) It is anticipated that the Policy Manual for Medical Review will be published by the Georgia Foundation.

b. The Peer Review of claims: (1) Appealed from the specialty panel decisions. (2) As requested by the Foundation Board.

The review mechanism of the Peer Review Committee will utilize the patterns of practice primarily, not the review of individual claims.

The results of the recommendations and of the decisions of the Peer Review Committee will be reported to the Foundation Board.

If the original decisions or recommendations of the consultant or of the specialty panel are modified by later review, the consultant, or the consultant and panel, will be notified. The reasons for the change will be provided. The Foundation is to be responsible for the transmission of this information.

c. The Peer Review Committee will have as one of its responsibilities the identification of educational needs as demonstrated by the review process. (1) The Peer Review Committee will notify the Committee on Education of its findings. It will cooperate with the Committee on Education in any way which

may be desired to develop satisfactory programs of education.

PEER REVIEW PROCESS

I. **Consultants** (Local Level)

A. Appointed by specialty societies
B. All consultants may:
1. Approve
2. Request additional information
3. Recommend:
a. Denial
b. Reduction
4. Refer claim to specialty panel
a. Consultants to be informed of changes and reasons for them.

II. **Specialty Panels** (One or more panels for each specialty)

A. Organization
1. Appointed by specialty societies and district president—conference
2. Panel members selected to represent geographic and population areas of the state
3. Each panel will elect its own chairman
B. Function
1. Review claims, including pattern of practice, referred by consultants.
2. Review claims appealed by physician, carrier, hospital (through URC) or patient
3. A single re-review of cases previously considered by it when accompanied by additional medical information.
4. Review claims appealed by medical consultants of carriers.
5. Identify and recommend administrative and procedural matters relating to the conduct of review.
6. Communicate either by telephone, letter, or personal interview with physicians whose individual claims or practice profile need either;
a. Additional information
b. Educational input
7. Communicated when necessary in a manner similar to number five above with patients regarding the amount of reimbursement.
8. Report all actions and recommendations to the Foundation Board of Directors.
9. At an appropriate time in the future, request official endorsement of the specialty society as the primary adjudicating body of their specific specialty.

III. **Peer Review Committee MAG**

A. Organization
1. Members as currently organized for MAG
a. Appointments to Committee recommended by the Specialty Societies and confirmed by MAG Council
2. Foundation Board Member
3. Foundation Staff Representation–Non-voting
B. Function
1. Policy
a. Develop medical policies for medical care review (subject to the approval of Foundation Board and of Council)
b. Prepare (or supervise the preparation of) Policy Manuals for Medical Care Review
2. Peer Review
a. As requested by the Foundation Board
b. The multispecialty peer review of appeals or referrals from decisions of specialty panels
c. The claims appealed from decisions of medical consultants of third party carriers would be referred to specialty panels—not initially to the Peer Review Committee
d. Patterns of practice to be the essential basis of this review, not individual claims.
3. Responsibility
a. Report to Foundation Board results of all peer review decisions or recommendations, and statement of reasons for any changes that have been advised.
4. Education
a. Identify educational needs as demonstrated by peer review.

IV. **Medical Care Foundation Board**

A. Organization
1. As defined
B. Function
1. Administrative and procedural for claims review
2. Development of plans and programs
3. Referral to MAG Peer Review Committee appeals of specialty panel decisions as felt appropriate.
C. Responsibility
1. Disseminate to all component specialty panels and consultants the results of peer review decisions or recommendations as cited in III. B. a. (above)

V. **Council of MAG**

A. Organization
1. As defined
B. Function
1. Final medical appeal of all claims involving medical care
2. Development of policy and of procedure

COMMITTEE OF PRIVATE PRACTICE AND HOSPITAL RELATIONS

W. Daniel Jordan, M.D.

This committee met in January 1974, and discussed various issues. Among the problems discussed have been: 1) the development of a Life sign™ card by a private company; 2) the evaluation of education protocol for emergency medical technicians; 3) the discussion and assessment of the "Killers and Cripplers" program; and 4) the evaluation and recommendations concerning an experimental program of exemption of small hospitals from certain audit procedures required by governmental agencies.

While the committee feels that there have been many issues that do affect the private practice of medicine and hospital relations, the most current and powerful one has been the issue of PSRO. This particular problem certainly has touched on almost every mem-

ber of MAG and will continue to remain in the forefront of activity.

The Private Practice Committee has no specific recommendations at this meeting but plans to explore multiple issues in the coming year. Of mounting importance and problems to be discussed in the future are: 1) the establishment of subsidized HMO's; 2) the public utility concept of health care; 3) mechanisms for improving the relationship between medical staffs and governing bodies of hospitals; and 4) methodology to define and strengthen the private practice of medicine by means of cementing the physician-patient relationship. It is anticipated that separate reports will be made to Council during the year concerning these individual topics.

COMMITTEE ON SCHOOL CHILD HEALTH

Fred Allman, Jr., M.D.

The School Child Health Committee has as its functions to stimulate cooperation by individual physicians in school health programs; to keep the profession informed on school health problems; and to encourage sanction by the medical profession of a sound school health program. To implement these goals the Committee has:

1. Sponsored, through the Medical Association of Georgia, an annual post-graduate course on the medical aspects of sports. A luncheon featuring a discussion of "Nutrition for the Athlete" attracted over 100 coaches and physicians at the last course.
2. Continued its efforts to develop an acceptable form to help classify students for physical education programs.
3. Formulated *Guidelines for Preadolescent Participation in Sports.*
4. Made two proposals in an effort to decrease deaths and injuries to athletes:

   (a) a proposal to establish certification requirements for coaches, with minimum standards of instruction in first aid, health, and other preventive measures;

   (b) a proposal to organize meetings in small communities to inform physicians, parents, coaches, and school administrators about the health of athletes.

In cooperation with the Georgia Society of Ophthalmology and Otolaryngology, the Georgia Academy of Pediatrics, and other groups, the Committee is coordinating programs for preschool screening of vision and hearing.

JOINT REPORT OF THE GRANTEE LIAISON OFFICER AND THE COORDINATOR OF THE GEORGIA REGIONAL MEDICAL PROGRAM

M. C. Adair, M.D., Grantee Liaison Officer
J. Gordon Barrow, M.D., Coordinator

As most of you know, Congress reversed President Nixon's decision to phase-out the Regional Medical Program. We have therefore received $1,322,000 in additional funds for the period July 1, 1973 through June 30, 1974 for the continuation, at a somewhat reduced level, of our approved program and these grants have already been made.

During the past year the National Association of Regional Medical Programs, Inc. brought suit against Health, Education and Welfare and the Office of Management and Budget to try to force release of the balance of the illegally impounded funds for fiscal year 1973 as well as a substantial amount of 1974 appropriated Regional Medical Program funds which had not yet been released. We are pleased to report that the Federal District Court in Washington has ruled in our favor and has ordered the Administration to release all these funds to the regions as rapidly as possible and to remove any restrictions they have placed on the regions as far as program content is concerned.

This will allow us to support staff and Regional Advisory Group approved programs during the period July 1, 1974 through June 30, 1975 regardless of what happens to the extension of the Regional Medical Program law in Congress. We are looking forward to another successful year and trust we will be able to continue to be productive in our efforts to assist physicians and other health professionals to provide better health care to the citizens of Georgia.

INTERSPECIALTY COUNCIL

Thomas E. Whitesides, Jr., M.D.

The Interspecialty Council of the Medical Association of Georgia, facing a change in its status due to changes in the bylaws and constitution of the Medical Association of Georgia, has met at regular intervals to help implement the possible changes and be ready for the added duties which it may be called upon to take on. Staggered terms were established for the members by lot according to their specialty society.

Several items brought to the Interspecialty Council were referred to each specialty group for opinion. These included the change in the annual session that has been suggested, the dissemination of information in regard to PSRO by furnishing personnel for discussion groups at each specialty society annual meeting, assistance with EMCRO, and the furnishing of opinion to the Medical Care Foundation in regard to various activities including opinion as to what constitutes a specialist, podiatrists, etc.

The composition of the Council is changing rapidly as each society is electing their appropriate representatives in anticipation of status change next May.

THE *JOURNAL*

Edgar Woody, Jr., M.D.

PERSONNEL

There have been no changes in staff; Donald J. McKenzie, M.D. of Thomasville has been added to the list of contributing editors.

STATE MEDICAL JOURNAL ADVERTISING BUREAU

The past few months have experienced decreasing revenue from national advertising as we feel the effects of "computer buying." Pharmaceutical firms prefer to

go to specialty or mass medical magazines where costs are less, even though state medical journals have good readership. Local ads are holding firm with several new ads in the past months.

A two-day seminar was held in Atlanta last October for state medical journal editors, managing editors, business and advertising managers. Panel discussions and speakers provided information and stimulation on increasing readership.

FORMAT AND DESIGN

Special effort was made to initiate many changes in typography and layout of the *Journal* with the January 1974 issue, while retaining the publications function and regular features. Changes made include a new size, 8¼ x 11, to conform with the majority of publications in the medical field, and redesigned cover logo, updated headline and body type. Response has been good.

CONTENTS

In October, a new series of human interest stories under the continuing title of "I've told this before . . ." was begun. The originator and sole contributor to date is J. G. McDaniel, M.D. of Atlanta whose stories have been well received. Others are encouraged to participate.

We have tried to cover Association news thoroughly from the special meetings held throughout the year to the ups and downs of the legislature. We continue to offer excellent scientific articles by Georgia physicians and educators, while striving to present special items—POW story in February, special issue in March on PSRO and April's theme of continuing education.

CREDITS

Headquarters staff is to be thanked for its continued efforts to plan and carry out the contents of each issue.

Contributing editors have been helpful in writing articles themselves and encouraging their colleagues to prepare and submit papers. The specialty pages add much to the contents of the *Journal* thanks to the efforts of Shirley Preston of the American Cancer Society, Georgia Division, Jerome Blumenthal, M.D., for the Georgia Heart Association, and Winston Huff of Powell, Goldstein, Frazer and Murphy for the Legal Page. The President's Letter from C. E. Bohler, M.D. has maintained consistent quality and timeliness throughout the year.

SUPPLEMENTAL REPORT OF THE COMMITTEE ON EDUCATION (SUBCOMMITTEE ON NURSING)

Nicholas Davies, M.D. and John P. Wilson, M.D.

Activities of the Committee on Nursing for the Medical Association of Georgia have been directed primarily in working with the Joint Practice Committee in developing parameters of practice for the extended role of the nurse. We have established liaison with the Georgia Nurses Association and feel that we are on the verge of significant development in determining guidelines of the role of nursing specialties.

As we see it at the present time, the primary needs are:

1. A cooperative effort at the local level (county and city) between representatives of nurses and physicians in determining their need for nurses in that particular community.
2. Willingness by physicians to accept nurses in appropriate extended roles.
3. Development of educational capability that will prepare the nurses effectively in specialized roles as well as some method of certification to assure adequate preparation and some quality control to be sure that the role designation is effective.

At the present time, a major problem that has arisen is that of the utilization of the nurse practitioner in some of the rural areas. We hope that this service can be developed commensurate with the delivery of good health and with the cooperative effort of physicians and nurses.

SUPPLEMENTAL REPORT OF COMMITTEE ON CANCER

Hoke Wammock, M.D.

The Annual Report of the Committee on Cancer was filed March 1, 1974. There has been no further meeting of the Committee on Cancer, but various members of the Committee on Cancer have been engaged in the development of the Statewide Cancer Management Network Program.

Briefly three grants were requested from the National Cancer Institute: One was for a continuation of an interim program of the Regional Medical Program from July 1, to December 31, 1973. This grant was not approved. A grant for a Statewide Cancer Network Program was requested, and this grant was not approved. We were advised to apply for grants:

1. Head and neck cancer.
2. Breast cancer.

We have been informed that the Breast Cancer Project has been approved. This will become activated July 1, 1974. We are now working on the method of implementing this program which will be rather comprehensive involving detection, treatment and rehabilitation. The Head and Neck Cancer Project was not approved.

We have a unique opportunity in the State of Georgia to coordinate the work of a number of organizations which have been active and effective in the fight against cancer for years. The Medical Association of Georgia has a lively interest in cancer channeled through a broadly representative Committee on Cancer.

We are now officially organized as a Statewide Cancer Management Network Program with representatives from various groups and individuals and lay people. From this, we have organized and elected an Executive Committee, and on this Executive Committee and Council are representatives of the Committee on Cancer of the Medical Association of Georgia.

The Speaker then proceeded to new business calling for the introduction of resolutions and requested that the "Resolved" portion only be read to the House. The following resolutions were then presented:

Resolution 74-1: Discriminatory Wage-Price Controls on Physicians—WITHDRAWN

Resolution 74-2: Dr. Heard's Candidacy for AMA Board of Trustees—Reference Committee D

Resolution 74-3: Creation and Procurement of Qualified Family Physicians—Reference Committee B

Resolution 74-4: Acceptance of PSRO Planning Contract—Reference Committee C

Resolution 74-5: Amend PSRO Law—Reference Committee C

Resolution 74-6: Medical Information Provided to Credit Bureaus—Reference Committee B

Resolution 74-7: Amendments to P.L. 92-603—Reference Committee C

Resolution 74-8: MAG Support of AMPAC—Reference Committee B

Resolution 74-9: PSRO—Reference Committee C

Resolution 74-10: Repeal PSRO—Reference Committee C

Speaker Rogers thanked all those members serving on Tellers, Credentials and Reference Committees and announced that the First Session of the House of Delegates would stand adjourned at 11:15 a.m.

Georgia Medical Political Action Committee Brunch

Saturday, May 11, 1974

The First Annual GaMPAC Brunch was held in the Ballroom at the DeSoto Hilton Hotel, Savannah, Georgia, at 10:00 a.m. on Saturday, May 11, 1974.

The invocation was offered by Carson B. Burgstiner, M.D. of Savannah.

J. Daniel Bateman, M.D., chairman of the Georgia Medical Political Action Committee, introduced those sitting at the head table as follows: J. Rhodes Haverty, M.D., MAG president-elect; Mrs. Mary Ellen Bateman, co-chairman of GaMPAC; C. E. Bohler, M.D., MAG President; Mr. Rusty Kidd, MAG staff; and Mr. James M. Moffett, MAG staff. He also recognized Mrs. John Bates, president of the MAG Auxiliary, and other distinguished guests present in the audience.

Dr. Bateman then presented GaMPAC awards as follows:

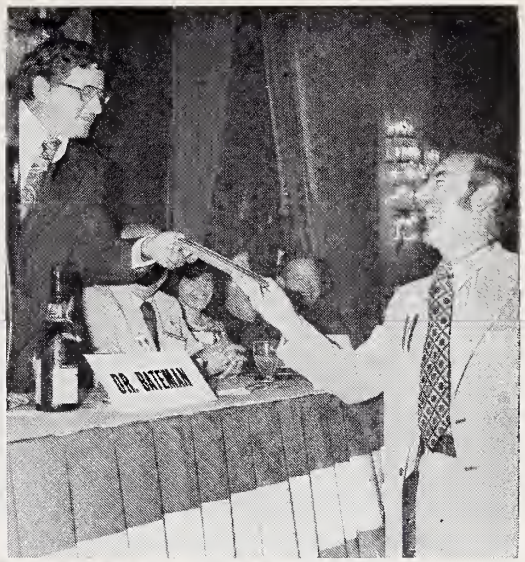
The first award to the county medical society reporting the highest percentage of GaMPAC members was given to three county societies, each of which reported 100 per cent participation. They were the Altamaha Medical Society, Emanuel County Medical Society and Telfair County Medical Society. The award for the congressional district PAC organization reporting the highest percentage of GaMPAC was given to the Fourth District GaMPAC. The third award is given to the doctors and their wives from that county medical society which contributes the most money to the GaMPAC Committee during the previous year. The 1973 winner was the Medical Association of Atlanta.

At this point Dr. Bateman introduced formally Rex Kenyon, M.D. of Oklahoma City, Oklahoma, and a member of the AMPAC Board of Directors. Dr. Kenyon gave brief remarks to the meeting.

Dr. Bateman introduced and presented to the audience Congressman Robert H. Michel of Illinois, chairman of the National Republican Congressional Campaign Committee. Congressman Michel delivered the keynote address.

Dr. Bateman adjourned the GaMPAC meeting at 11:55 a.m. and turned the podium over to C. E. Bohler, M.D., MAG president, for the purpose of conducting the memorial service and awards program of the Medical Association of Georgia.





High spirits characterized the first annual GaMPAC brunch, led off by a rendition of "Your Cheatin' Heart" by Lt. Gov. Lester Maddox accompanied by a Savannah Dixieland band; Luther Vinton of Avondale Estates happily accepts a GaMPAC award for the Fourth District which reported the highest percentage of membership, from J. Dan Bateman, GaMPAC chairman.

MAG Second General Session

1974 Annual Session Business Meeting Saturday, May 11, 1974

THE SECOND GENERAL SESSION of the 1974 Annual Session Business Meeting of the Medical Association of Georgia was called to order on Saturday, May 11, 1974, by C. E. Bohler, M.D., MAG president, at 12:00 noon in the Ballroom of the DeSoto Hilton Hotel, Savannah, Georgia.

Dr. Bohler called on Mrs. Robert Quattlebaum of Savannah to lead the assembly in a brief devotional in memory of our departed colleagues and loved ones. Mrs. Quattlebaum read an appropriate poem followed by a reading of the list of those colleagues and wives of colleagues who had died since the 1973 Annual Session. They were as follows:

Harold W. Adams, Atlanta, February 26, 1974
R. B. Ansley, Decatur, November 1, 1973
Crawford F. Barnett, Atlanta, November 3, 1973
Wallace Lee Bazemore, Macon, April 24, 1974
Frank Bird, Lake Park, November 28, 1973
Walter E. Brown, Savannah, March 12, 1974
John D. Campbell, Atlanta, October 31, 1973
Gordon Chason, Bainbridge, March 9, 1974
R. Carter Davis, Atlanta, May 6, 1973
George R. Dillinger, Thomasville, April 15, 1973
William Lamar Dobes, Atlanta, February 9, 1974
J. K. Fancher, Atlanta, April 24, 1974
Henry Ray Fenn, Americus, April 1, 1974
Thomas E. Fulghum, Dalton, March 29, 1974
Ira Goldberg, Augusta, April 29, 1973
Edward A. Gonzalez, Rome, September 14, 1973
Rufus E. Graham, Savannah, March 28, 1974
Eugene L. Griffin, Atlanta, September 2, 1973
O. Emerson Ham, Sr., Savannah, April 28, 1974
Thomas Harrold, Macon, May 29, 1973
Haywood N. Hill, Atlanta, December 1, 1973
L. D. Hoppe, Atlanta, July 27, 1973
H. Walker Jernigan, Atlanta, January 23, 1974
McClaren Johnson, Jr., Atlanta, November 7, 1973
Peter Kwiatkowski, Brunswick, February 13, 1974
C. J. Maloy, Helena, January 4, 1973
M. D. McCall, Jr., Acworth, November 27, 1973
Joseph H. McCormick, Savannah, February 21, 1974
William B. McMath, Americus, March 13, 1974
W. O. Martin, Jr., Atlanta, April 9, 1973
W. W. Meriwether, Macon, June 12, 1973
John M. Miller, Augusta, April 23, 1972
F. C. Nesbit, Covington, May 10, 1973
Virgil W. Osborne, Decatur, November 1, 1973
W. L. Osteen, Savannah, May 8, 1974
A. M. Phillips, Macon, April 9, 1973
C. E. Powell, Swainsboro, February 12, 1973
C. M. Pugh, Lumpkin, November 27, 1973

John H. Robbins, Athens, December 14, 1973
J. R. Sams, Covington, May 1, 1974
Collis N. Tomblin, Columbus, May 13, 1973
Claude V. Vansant, Jr., Douglasville, September 13, 1973
J. Frank Walker, Atlanta, October 6, 1973
Bithel Wall, Americus, July 7, 1973
James B. Wilbanks, Clarkesville, November 11, 1973
William J. Williams, Augusta, February 14, 1974
C. H. Willis, Jr., Augusta, February 8, 1974
Herbert W. Wingate, Albany, July 22, 1973

Auxiliary Deceased Members

Mrs. Howard M. Coe, Brunswick
Mrs. Marshall Hall, Macon
Mrs. Charles C. Hinton, Macon
Mrs. Edwin C. Jungck, North Augusta, S.C.
Mrs. J. C. Patterson, Cuthbert
Mrs. C. A. Rhodes, Atlanta
Mrs. Lewis Ridley, Jr., Macon
Mrs. Charles O. Walker, Donalsonville

AMA-ERF

President Bohler then presented to the two medical schools in Georgia unrestricted grant monies in the form of AMA-ERF checks raised by contributions from physicians and Woman's Auxiliary during the previous year. Dr. Bohler presented the checks as follows:

To Curtis Carter, M.D., dean of the Medical College of Georgia, a check was presented in the amount of $6,277.

Arthur Richardson, M.D., dean of Emory University School of Medicine was not present and Fleming Jolley, M.D. accepted on behalf of the Emory Medical School a check in the amount of $7,148.

Fifty Year Pins and Certificates

H. Hilt Hammett, M.D. was asked to present the 50-Year Certificates and Pins to those members who were graduated from medical school and licensed to practice medicine 50 years ago. They were:

Herbert Steed Alden, Atlanta; George H. Alexander, Forsyth; Henry J. Copeland, Griffin; Waldo E. Floyd, Statesboro; Robert C. McGahee, Augusta; Calvin B. Stewart, Atlanta; George A. Williams, Atlanta.



One of 16 physicians honored with Life Membership Cards is J. G. McDaniel of Atlanta, congratulated by Second Vice President Luther Thomas of Augusta.

Life Membership

Dr. Bohler called on Luther Thomas, M.D., second vice president of MAG, to present special gold membership cards to MAG Life Members as follows:

B. Russell Burke, Atlanta; W. Elizabeth Gambrell, Atlanta; Abraham Herman Germain, Jonesboro; John H. Jackson, Barnesville; Ruskin King, Savannah; J. G. McDaniel, Atlanta; W. M. Moncrief, Atlanta; R. P. Neville, Savannah; Robert L. Oliver, Savannah; Samuel W. Perry, Atlanta; W. L. Pomeroy, Waycross; Lewis L. Rawls, Macon; Walter P. Rhyne, Albany; Paul T. Scoggins, Commerce; Carter Smith, Sr., Atlanta; John R. Walker, Atlanta.

Certificates of Appreciation

President Bohler called on Earnest C. Atkins, MAG Secretary, to present the Certificates of Appreciation to individuals deserving of special recognition for their contributions to medicine as follows:

C. E. Bohler, M.D., as MAG president 1973-74; H. Hilt Hammett, M.D., as MAG first vice president 1973-74; Harrison L. Rogers, M.D., as speaker, MAG House of Delegates 1969-74; W. E. Barron, M.D., as Sixth District councilor 1972-74; David A. Wells, M.D., as Seventh District councilor 1970-74 and chairman of Council 1972-74; J. Frank Walker, M.D., as AMA delegate 1965-73, presented to Mrs. Walker; Preston D. Ellington, M.D., as AMA delegate 1962-74 and chairman, MAG Committee on Annual Sessions, 1969-74; F. W. Dowda, M.D., as AMA alternate delegate 1968-74, Georgia Medical Care Foundation president 1970-74 and EMCRO principal investigator 1971-74; J. Daniel Bateman, M.D., as AMA alternate delegate 1969-74; W. H. Pool, Jr., M.D., as chairman, MAG Committee on Medicine and Religion, 1970-74; Mrs. John G. Bates as president, Woman's Auxiliary to the Medical Association of Georgia 1973-74; Ollie O. McGahee, M.D., as chairman, EMCRO Committee 1973-74; Charles D. Hollis, M.D., as chairman, PSRO Committee 1973-74; William J. Morton, M.D., as member and chairman of the Composite State Board of Medical Examiners.

Rep. Dawson Mathis for outstanding service to health care legislation 1974; Rep. John J. Flynt for outstanding service to health care legislation 1974; Sen. Maylon London for outstanding service to health care legislation 1974; Sen. Edward H. Zipperer for outstanding service to health care legislation 1974; Sen. W. W. Fincher, Jr., for outstanding service to health care legislation 1974; Rep. Chappell Mathews for outstanding service to health care legislation 1974; Rep. Roy McCracken for outstanding service to health care legislation 1974; Rep. Ben Blackburn, III, for outstanding service to health care legislation 1974; Rep. Jack Brinkley for outstanding service to health care legislation 1974; Lt. Gov. Lester Maddox for outstanding service to health care legislation 1974; Sen. Herman E.



Named "Family Physician of the Year," Ollie O. McGahee of Jesup is congratulated by Edwin Flournoy of Albany, president of the Georgia Academy of Family Physicians.



MAG's highest honor, the Distinguished Service Award is presented to John L. Elliott of Savannah by President Bohler.

Talmadge for outstanding service to health care legislation 1974.

Family Physician of the Year Award

Each year MAG presents an award to the Family Physician of the Year and calls upon the Board of Directors of the Georgia Academy of Family Physicians to select the recipient of this award. At this time, Dr. Bohler called on Edwin Flournoy, M.D., president of the Georgia Academy of Family Physicians, to present this award.

Dr. Flournoy announced that the Georgia Academy of Family Physicians had selected as the 1974 recipient Ollie O. McGahee, M.D. of Jesup, Georgia.

Civic Endeavor Award

A special award to honor those physicians who are active in civic affairs was created by MAG in 1968. President Bohler advised the audience that the recipient of this award annually is selected by a secret committee which evaluates nominations made by the county medical societies.

Dr. Bohler announced that the 1974 recipient was Robert S. Donner, M.D. of Macon.

Distinguished Service Award

The highest honor that the Medical Association of Georgia can bestow upon one of its members in recognition of service to the Association is the Distinguished Service Award. At this point Dr Bohler announced that the recipient of the 1974 Distinguished Award was John L. Elliott, M.D. of Savannah

Following several brief announcements, President Bohler adjourned the meeting at 12:45 pm.

Second Session House of Delegates

Sunday, May 12, 1974

THE SECOND SESSION of the House of Delegates of the Medical Association's 1974 Annual Session Business Meeting was called to order at 9:00 a.m. by Speaker Harrison L. Rogers, Jr., M.D., Atlanta, in the Ballroom of the DeSoto Hilton Hotel in Savannah, Georgia, on Sunday, May 12, 1974.

Speaker Rogers called for a report on attendance and Bruce Newsom, M.D., speaking for the Credentials Committee, reported that in excess of 40 delegates were present and accounted for, that a quorum was present and, therefore, the House could proceed with business. The Speaker declared a quorum present and the House of Delegates to be duly in session.

(The Credentials Committee made the following complete report on attendance at the close of the meeting.)

Attendance

In the compilation of attendance taken from the official roll 40 county medical societies were represented by their delegates or alternates. In total, 144 delegates were present at the Second Session. They were as follows:

BALDWIN: Edwin W. Allen, Jr. and W. T. Smith; BARTOW: R. A. Griffin, III; BIBB: C. A. Duggan, John G. Etheridge, Jasper T. Hogan, C. G. Magnan,

Jr., Jack F. Menendez, S. Charlotte Neuberg, W. J. O'Shaughnessey, Jr. and B. B. Sanders; OGEECHEE RIVER: Leon E. Curry; CARROLL-DOUGLAS-HARALSON: J. Larry Boss and Clark Robinson; GEORGIA MEDICAL SOCIETY: J. Patrick Evans, Thomas A. Hetherington, Frank M. Johnston, J. Moultrie Lee, J. Robert Logan, F. D. Maner, J. A. Mulherin, D. A. Nash and J. K. Quattlebaum; ELBERT: Carey A. Mickel; CHATTAHOOCHEE: Rupert H. Bramblett and Cecil L. Miller; CHEROKEE-PICKENS: L. Austin Flint; CRAWFORD W. LONG: W. L. Bowen, Jr., and A. D. Muse; CLAYTON-FAYETTE: Wells Riley; COBB: F. Norman Bowles, Robert P. Coggins, James H. Manning, J. Gary Palmer, Harry Porter, Jr., Charles J. Rey, Jr., Donald R. Rooney and C. R. Underwood; DEKALB: Stanley P. Aldridge, Paul Black, H. Duane Blair, L. C. Buchanan, L. L. Freeman, William R. Hardcastle, Timothy Harden, Jr., Charles W. McDowell, LaMar McGinnis, William J. Rawls and Roy W. Vandiver; DOUGHERTY: J. D. Bateman, D. M. Boyette, Charles D. Hollis, Jr. and Robert D. Waller; FLOYD-POLK-CHATTOOGA: John F. Atha, Charlie O. Sennett and James H. Smith; EMANUEL: R. J. Moye; MEDICAL ASSOCIATION OF ATLANTA: Earl Hathcock, C. R. Moorhead, Bob G. Lanier, W. D. Jordan, L. N. Turk, Howard S. Brown, Joseph S. Wilson, John C. Hall, Stewart Wiegand, F. W. Dowda, Robert L. Brown, Fleming Jolley, Frank L. Wilson, J. Harold Harrison, L. H. Felder, Charles E. Harrison, Jr., J. R. B. Hutchinson, W. C. Waters, John M. McCoy, John R. McCain, Keith A. Quarterman, Edwin C. Evans, John K. Schellack, E. L. Graydon, W. D. Logan, James A. Kaufmann, Charles E. Todd, D. G. Whitney, John S. Atwater, Harrison L. Rogers, Jr., Thomas L. Tidmore, Jr., John Rhodes Haverty, Armand Hendee, W. W. Moore and Edward J. Waits; GLYNN: Ben T. Galloway, Michael A. Glucksman and W. Jack Smith; HALL: Harvey M. Newman, III, Lawrence N. Durisch, Jr. and Charles K. Bradley; PEACHBELT: Carl L. Crawford and B. Lamar Pilcher; JACKSON-BANKS: Paul T. Scoggins; LAURENS: O. B. Johnson; MITCHELL: Jack Hudson; MUSCOGEE: Floyd C. Jarrell, Jr., J. A. Raines, James H. Sullivan, B. Maughon, Bruce C. Newsom and John H. Deaton; OCONEE: H. A. Thornton; RANDOLPH-STEWART-TERRELL: John G. Bates; RICHMOND: Stuart A. Prather, Jr., William E. Barfield, Preston D. Ellington, Tom Douglass, Luther M. Thomas, Jr., Ronald F. Galloway, Claud Boyd, J. Kenneth McDonald, Henry D. Scoggins, Donald C. Abele, Horace H. Osborne, Daniel B. Sullivan and John M. Martin; SOUTH GEORGIA: Joe C. Stubbs; SPALDING: Henry Arthur Foster and James M. Skinner; STEPHENS: C. P. Lampros; THOMAS-BROOKS-GRADY: Gerald B. Muller and Maurice Tanner; TIFT: W. O. Holloway; TROUP: Joseph M. Almand, Jr. and H. Hilt Hammett, Jr.; UPSON: T. A. Sappington; WALKER-CATOOSA-DADE: Ted D. Cash and M. K. Cureton; WARE: S. William Clark and Floyd Davis; WASHINGTON: W. S. Helton; WAYNE: Ollie O. McGahee, Jr.; WHITFIELD: John G. Forshner, Earl T. McGhee and James J. Oosterhoudt; WILKES: M. C. Adair; SAMA: Joseph Keenan.

Elections

Speaker Rogers reminded the House that they had been given ballots by the Credentials Committee and that at this time they should cast ballots for the office of second vice president by writing in either the name Joseph M. Almand or W. Daniel Jordan; and for the office of vice speaker of the MAG House of Delegates, they should write in the name of either Jack Raines or Ronald F. Galloway. The Speaker then read the names of those candidates for other offices that were uncontested and instructed the Secretary to cast a unanimous ballot for this slate. These were President-elect—David A. Wells; Speaker—L. C. Buchanan; AMA delegate—J. Daniel Bateman; AMA delegate—Harrison L. Rogers, Jr.; AMA delegate (Walker's unexpired term)—Harrison L. Rogers, Jr.; AMA alternate—C. Emory Bohler; AMA alternate—F. William Dowda.

At this point the balloting for the office of Second Vice President and Vice Speaker of the House of Delegates was conducted by the Tellers Committee.

Reference Committee Reports

Speaker Rogers called for reports from the Reference Committee chairmen. He reiterated the procedure to be followed stating that if no discussion or dissent followed each portion of the Reference Committee report, he would rule the item adopted as introduced, pending a final vote on the report as a whole at the conclusion of each Reference Committee report.

REPORT OF REFERENCE COMMITTEE A

R. J. Moye, M.D., Chairman

Chairman Moye reported to the House that reports and resolutions referred to Reference Committee A had been considered by the committee which met at 1:00 p.m. in the Harborview Room North of the DeSoto Hilton Hotel in Savannah, Georgia, on May 10, 1974. Members of the Reference Committee present included R. J. Moye, M.D., Swainsboro, chairman; J. H. Smith, M.D., Rome, vice chairman; James Moultrie Lee, M.D., Savannah; Cecil L. Miller, M.D., Buford; J. Gary Palmer, M.D., Marietta; and W. D. Logan, M.D., Atlanta.

FIRST VICE PRESIDENT

H. Hilt Hammett, Jr., M.D.

Doctors of medicine must continue to perform and serve. The American doctor has shown that it is possible on a large scale and by strictly voluntary methods not only to support and help his patients prepay their medical bills, but at the same time, to preserve the factors of free choice, fee for service, and private patient-physician relationship. We must be responsible and accountable and demonstrate our performance with logic and facts. Medicine in America must focus strong attention on the fact that the key to continued excellence in medical care is the system that allows you to

select your own physician and for your physician to practice medicine freely without undue legislative restrictions.

Our job is to continually minimize the important difference between what things are and what they ought to be. It is absolutely imperative that doctors of medicine fight with every ethical method possible the continuing invasion of any government in the profession of medicine.

We must never forget that government, however necessary, has nothing to give but that which it first takes away. It is a fact that the political give-away is first the political take-away. Government is not a producer, it is a consumer. We talk much about our rights —the rights of medicine, the rights of minorities, civil rights, and all kinds of rights. Much of this is healthy and needed. But here is the price tag: There are no rights without duties; and among free men, there are no privileges without responsibilities.

The dangers of our time are the dangers of complacency, of apathy, of plain sorry laziness. There are far too many of us who are too lazy to work for the profession of medicine; but worse still, there are many more of us who are too busy and lazy to think for medicine and act accordingly.

Nothing at the top can make up for indolence, apathy, and ignorance below. If each person connected with the profession of medicine would seek to learn the meaning and dangers of the governmental invasion and bureaucratic controls being rammed down our apathetic anatomy, and then actively participate in every ethical and moral manner possible to destroy same, the collective force would be unsurmountable.

RECOMMENDATION

I recommend for your consideration and action as individuals and as members of the Medical Association of Georgia, that the battle cannot be won if we simply exercise our rights and yet fail to carry out our equal share of responsibility.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of this report with commendation.

HOUSE OF DELEGATES ACTION—Adopted the report of the First Vice President.

BIBB COUNTY MEDICAL SOCIETY COUNCILOR AND VICE COUNCILOR

Braswell E. Collins, M.D., Councilor and Milton I. Johnson, Jr., M.D., Vice Councilor

The Bibb County Medical Society has made much progress as an integral part of the Medical Association of Georgia.

A new Constitution and By-Laws were adopted to keep pace with those of the Medical Association of Georgia.

The Society continued to improve relations with government officials, news media and community groups. A twice monthly television program was provided with the "right physician for the right topic."

Great efforts were made to join in the establishment of a Medical School at Mercer University. Two hundred thousand dollars was set as a goal for the Society members.

The Society has been actively involved in working for the repeal of PSRO. An every member mailing urged all members to contact his senators and congressmen seeking support in repeal of PSRO.

Twenty new members were added in 1973.

RECOMMENDATIONS

That MAG Council publicize its quarterly meetings in advance to a greater extent to the general membership. MAG members should be informed of the sincere welcome for them to attend Council as visitors. In this way the membership would have a better understanding of Council activities.

SIXTH DISTRICT MEMBERSHIP

County and Secretary	Members December 31, 1972 MAG	Members December 31, 1972 AMA Dues Paying Only	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only
Bibb				
James B. Lindsay				
Macon	180	153	190	172

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee agrees in principle with the recommendation made in this report, but feels that the mechanics are already available since this information is published in the *Journal of the Medical Association of Georgia* and in meeting highlights sent to county medical society officers and MAG councilors and vice councilors. We would like to further recommend that the county medical society officers make special efforts to communicate the dates and places of these meetings to all of their members so that they might attend and observe the actions of the MAG Council and Executive Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Reference Committee.

DEKALB COUNTY MEDICAL SOCIETY COUNCILOR

L. C. Buchanan, M.D.

As Councilor for the DeKalb County Medical Society during the year 1973-74, I have regularly attended the meetings of Council and most of the meetings of Executive Committee of Council, though I am not formally a member of the latter body. After each meeting of Council, I have reported to the Board of Trustees of my local Medical Society and, when asked to do so on a number of occasions, have addressed the entire membership as a whole on matters in which Council has taken definitive action.

I have been particularly active in the field of the Public Law 92-603 as applied to the PSRO provision, have written two editorials for the MAG *Journal,* have been a member of the delegation to visit with our Congressional Representatives in Washington on three occasions, and have spoken to several medical societies in the state on PSRO. During the year I have served as a liaison person between the Insurance and Economics Committee and Council, and of the Georgia Medical Care Foundation and Council, being members of each of the groups named.

Excellent cooperation has been obtained from our vice-councilor, Luther M. Vinton, M.D. who has supported our efforts and has been regular in his attendance to meetings described above.

RECOMMENDATION

The only recommendation submitted is of a general nature to the end that MAG, in all levels of its structure, will continue to increase its efforts to involve a greater number of physicians in the work of the organization, and particularly involvement of newer members by definite responsibility assignments to them.

FOURTH DISTRICT MEMBERSHIP

County and Secretary	Members December 31, 1972 MAG	Members December 31, 1972 AMA Dues Paying Only	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only
DeKalb				
Stanley P. Aldridge				
Decatur	242	210	242	214

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval with commendation of this report.

HOUSE OF DELEGATES ACTION—Adopted the report of the DeKalb County Medical Society councilor.

GEORGIA MEDICAL SOCIETY COUNCILOR

L. Richard Lanier, Jr., M.D.

It is with greatest pride that we welcome each of you officers, delegates, councilors, members and guests to Savannah, the home of Georgia's oldest medical society for the Annual Session of the Medical Association of Georgia.

The Georgia Medical Society has had its year of successes and frustrations and debates and debacles. This report and recommendations are based on these proceedings of the business of the Georgia Medical Society.

The Emergency Medical Service Committee under Drs. Irving Victor and Benjamin A. McReynolds have succeeded in having a county-wide Emergency Medical Service established with the vehicles equipped with telecommunications to the Emergency Rooms. Experience with this should result in better emergency care for those in need.

A great deal of debate and concern of the Georgia Medical Society has been for the protection of the rights of the average member in dealing with third parties. Injustices do occur, both due to the member's errors, but more frustratingly, due to the capriciousness of petty bureaucrats. This will be considered in the Recommendation Number 1.

Chatham County during the year was presented with a closed panel health maintenance organization. This is government sponsored and apparently slipped in through the back door of both the county and state medical society and this will be the basis of my Recommendation Number 2.

RECOMMENDATIONS

(1) In connection with the use of the WATS Line, each member should be notified that he does have a hot line number for his complaints as related to third party problem. This hot line should be manned with someone knowledgeable in the ways of bureaucracy. Complaints should be identified and referred, either individually or as a common group, where this is the case, to the Committee on Private Practice. The Committee on Private Practice should act as an intermediary to help the physician secure justice and fairness. The Committee should also present areas of injustice and unfairness that arise that need the efforts of the entire Medical Association to the Council or the House of Delegates so that appropriate action might be taken, and where necessary, legislative campaigns be initiated.

(2) That the Medical Association of Georgia should formulate guidelines and policies regarding relationships to members of closed panel HMOs, and further that the staff should be alert for the possible formation of these closed panel organizations, and alert those societies and officers that might be involved; and that the Medical Association of Georgia investigate the possibility of forming an open HMO, either as a new corporation, or through the Foundation to offer a capitulation contract for HMO type services throughout the State of Georgia and avoid the fragmentation that might develop with each county medical society or district medical society forming its own open panel HMO.

FIRST DISTRICT MEMBERSHIP

County and Secretary	Members December 31, 1972 MAG	Members December 31, 1972 AMA Dues Paying Only	Members December 31, 1973 MAG	Members December 31, 1973 AMA Dues Paying Only
Georgia Medical Society				
J. Robert Logan				
Savannah	210	194	219	200

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends disapproval of Recommendation 1 of this report since assistance is currently available through the Georgia Medical Care Foundation to all physicians not only for Medicaid information and assistance but for any third-party carrier. For further information of the House, the Georgia Medical Care Foundation has a WATS line #1-(800)-282-2614 that has been installed for the purpose of assisting physicians with problems. Under Recommendation 2 the Reference Committee recommends disapproval of the recommendation as written and would offer the following recommendation as a substitute: "The Medical Association of Georgia should formulate guidelines and policies on the formation of HMOs and communicate this information to the membership. The committee would like to further recommend that the Medical Association of Georgia offer assistance when requested to county medical societies or other appropriate groups wishing to establish or maintain an emergency medical services program."

HOUSE OF DELEGATES ACTION—A floor amendment was offered and agreed to which changed the second from the last sentence in the Reference Committee recommendation. That sentence would now read "The Medical Association of Georgia

should form a committee to study guidelines and policies on the formation of HMOs and communication this information to the membership." The House adopted this report of the Reference Committee as amended on the floor.

AD HOC COMMITTEE ON ACCESS TO HEALTH CARE

M. C. Adair, M.D.

The members of the Ad Hoc Committee on Access to Health Care feel that there should be more dialogue between the Medical Association, the medical schools, and representatives of the consumers. It was the consensus of the Committee that an on-going group within the Association should develop this dialogue. This ongoing committee should look into the question of the provision of health care around the state. Another aspect of this committee's activities should deal with the problem of getting the patient into the health care system and educating the people on how the health care system should be used.

This committee activity could function as a new committee of MAG or as a sub-committee of the MAG Rural Health Committee. In either case, however, the Committee feels that there should be input from cunsumer representatives as well as medical school representatives.

After considerable discussion, the Committee feels that several recommendations could be made concerning problems of access to health care.

RECOMMENDATIONS

1. MAG should consider legislative action, if appropriate, or resolutions to AMA, if necessary, to achieve some means of compensation from third parties for nurse mid-wives, physicians' assistants, or other qualified paramedical personnel. The reimbursement should be made to the employing hospital, physician or corporate employer, rather than directly to the individual paramedical person.

2. MAG should make the public aware that every community that wants a physician does not necessarily need a physician, nor can it support one; a) the Georgia State Medical Education Board should be supported in its continuing efforts to place physicians in rural communities through loans supporting medical students; b) the National Health Service Corps placement of physicians should be considered as a potential for solving the access problem in some communities; c) MAG should consider the development of general criteria or standards for placement of physicians in a community.

3. There should be a coordination of funding for health programs so that a project can achieve completion and that all phases of the problem be covered by the funding, rather than have fragmented funding support and annual threats of loss of funds.

4. The MAG should make its county medical societies and the public aware of what has been done around the state in various communities as far as improving access to health care so that others will be able to use these suggestions for their own areas.

5. MAG should offer strong support for the continued training of family practitioners, establishment of family practice residencies, preceptorships and in general, improvement of the image of the family practitioner in the medical profession.

6. MAG should evaluate the growth of group practice of primary medical physicians in smaller communities.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends continuation of the Committee on Access to Health Care as a standing committee or subcommittee. Your committee recommends disapproval of Recommendation 1 of the report. Your Reference Committee recommends that you approve Recommendation 2. It is recommended by your committee that you approve Recommendation 3 for information only. Your Reference Committee further recommends that Recommendations 4, 5 and 6 of this report be approved as written.

HOUSE OF DELEGATES ACTION—Adopted the report of the Ad Hoc Committee on Access to Health Care as amended by the Reference Committee.

RURAL HEALTH COMMITTEE

Irving D. Hellenga, M.D.

The Rural Health Committee has received substantial aid and support during the year from Mr. Carl Bailey, staff member, and this support and assistance was in several areas. Initially, we had the privilege of attending with our wives the National Rural Health Conference in Dallas, occurring as it did in March of 1973. Contact with leaders in the field of medical planning and development was valuable to us.

Our next task was in arranging and conducting the Ninth Annual Georgia Rural Health Conference, held at the Macon Hilton on August 29, 1973. The theme of the conference was "The Changing Role of State Government in Health Care and Environmental Services." Mr. Richard Harden, commissioner of the Department of Human Resources, and Lt. Governor Lester Maddox participated in the discussion. Additional participants in the conference were Dr George F. Green, discussing "The Role of Physician Assistant," Dr. John Rhodes Haverty, discussing "The Role of Allied Health Personnel" and Dr. W. Newton Long of Emory, discussing "The Role of the Nurse-Midwife." Real assistance for the conference was obtained from our co-sponsors, The Georgia Farm Bureau and the Extension Service of the University of Georgia. Most of those attending the conference were from those two organizations. It is hoped that there will be a broad based attendance, including members of MAG, at our upcoming conference, once again Macon-based, on August 28 and 29, 1974.

As a result of Mr. Harden's participation in our past conference, we as members of the Rural Health Committee subsequently discussed in his office how we might further promote the DHR's program "Killers and Cripplers." We have added Dr. Albert Schoenbucher of DHR to our Committee; we also proposed visiting in the various districts of the state to present the program "Killers and Cripplers."

In April 1974 it is our intention to visit once again the National Rural Health Conference meeting in Detroit. Appropriate report of this conference will be made as required.

The assistance of each member of the Committee and of each member of the staff who has helped, is acknowledged at this time.

RECOMMENDATION

It is the recommendation of the committee that the "Killers and Cripplers" program be made part of a District Meeting, with visiting personnel from the Area Networks of DHR in attendance.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends that you disapprove the recommendation in this report and would offer the following substitution: "MAG should develop viable liaison with the Department of Human Resources and utilize such programs and materials as seems appropriate from this agency."

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Rural Health as amended by the Reference Committee.

COMMITTEE ON COMMUNICATIONS

Robert P. Wight, M.D.

In the Fiscal Year 1973-74 the Communications Committee was granted the largest budget ever allocated to a committee. We feel that we have been prudent and extremely effective in the usage of these funds and point with pride to successes of the Association brought about in part by Committee efforts.

This was the first full year of staff support at the headquarters level. Also we have strengthened our Committee with the addition of several new members.

For the general membership, we have produced a general information brochure and flyers, a committee chairman's handbook, media code and sponsored a practice management workshop. Additionally, we have worked on specific projects with county societies and made additional new member contacts through the Flex examination in Atlanta.

The MAGNET Conference is a most significant activity of the Committee. This year over 100 members registered to hear discussions on communications, national health legislation in general and Professional Standards Review Organizations in particular. Our approach to MAGNET this year was to make an issue oriented forum as well as an informational session for new society officers. We see two very positive achievements derived from MAGNET. First we definitely improved our lines of communications with the news media. Secondly, through MAGNET the Association's opposition to PSRO was crystallized.

Our speakers included E. B. Howard, M.D. and Robert Hunter, M.D. of the AMA and Reg Murphy, editor of the *Atlanta Constitution*.

In the area of legislation, the Committee again produced news clips from the Capitol using legislators from around the state discussing various bills that MAG had interest in. This is a highly successful program and we plan to continue it.

Media relations continues to be a strong aspect of our activities. This is evidenced by the increasing requests for information and participation from the news media.

During the year, several articles were generated from our activities and three hours of television were arranged from the state level, discussing various health care issues. We have attempted, with some success to have county societies become more active with their local media. This will be an on-going effort on our part.

The general public has become more aware of MAG involvement through various news releases during the year.

Other visible efforts by MAG to be a public service oriented organization were our sponsorship of advertising of educational television health care programs and the taping of radio public service announcements for statewide distribution. We intend to continue our monitoring of public opinion and looking for effective ways to express MAG policy positions.

RECOMMENDATIONS

Membership

1. The Committee is actively aware of the need to attract new members and retain old ones. It is recommended that our Committee in concert with the Membership Committee establish liaison to accomplish these goals. It is further recommended that MAG's field representatives be utilized fully in this membership effort.
2. It is recommended that each committee provide information about their activities that would be suitable for public dissemination. It is further recommended that the staff member assigned to each committee should be responsible for the gathering of this information and supplying it to the Communications Committee.
3. It is recommended that MAGNET be continued under the format established this year.

Public

1. It is recommended that the legislative news spot program be continued.
2. It is recommended that the Committee expand its efforts to gain positive public response to MAG programs and positions. This is to be done by continuing our radio public service announcements and intensified media contact efforts.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of this report with the additional comment that every attempt should be made to gain more significant membership participation in the 1974 MAGNET.

HOUSE OF DELEGATES ACTION—Adopted the report of the Communications Committee with the additional recommendation made by the Reference Committee.

Chairman Moye expressed his appreciation to the members of the Reference Committee for their time and effort and moved that the Reference Committee report be approved as a whole as amended. This motion was duly seconded and approved.

REPORT OF REFERENCE COMMITTEE B

S. W. Clark, M.D., Chairman

Chairman Clark reported to the House of Delegates that the reports and resolutions referred to Reference Committee B had been considered by the committee which met at 1:00 p.m. in the Harbor-

view South, DeSoto Hilton Hotel, Savannah, Georgia, on May 10, 1974. The members of the committee present included S. W. Clark, M.D., Waycross, chairman; Frank L. Wilson, M.D., Atlanta; Harvey Newnan, M.D., Gainesville; and Charles McDowell, M.D., Decatur.

THE PRESIDENT

C. E. Bohler, M.D.

Your Medical Association of Georgia remains strong and continues to grow. Financially, we are in good condition and I predict the Association will continue to progress. It will be a pleasure to hand the gavel to the Presidency of an ongoing and vigorous organization to my good friend and successor, Dr. Rhodes Haverty and wish him well.

I will not attempt to list all the accomplishments of the past year; this information is readily available to any member of the MAG in the minutes of Council and Executive Committee.

The highlights of this past year has been MAG's decisions concerning the Experimental Medical Care Review Organization (EMCRO) and Professional Standards Review Organization (PSRO).

At the called session of the House of Delegates in December, it was decided to allow EMCRO to go operational, provided there would be no expenditure of MAG funds. On the second day of the session, the Delegates voted to work for repeal of PSRO. The latter action will be a most expensive undertaking; of both money and manpower.

Your President and others of the Executive Committee went to Washington and talked with Georgia's Senior Senator and 80 per cent of our Congressmen. We came away with the impression that PSRO can *perhaps* be repealed or favorably amended; however, our Senior Senator is not among those who favor repeal of PSRO. Your Executive Committee and the PSRO Committee will continue to work vigorously to carry out the directives of the House of Delegates. If after six or 10 or 12 months of hard and concerted and expensive work by MAG, it becomes evident that PSRO will not be repealed and we are faced with the dilemma of compliance or non-compliance, would it not be well if we had an alternative plan to offer our members? I feel we should instruct our PSRO Committee to develop frameworks for more than one possible alternative. We can get favorable amendments or changes in the law.

RECOMMENDATIONS

Many members of MAG have expressed a great deal of concern about physicians' assistants; their training, their privileges, their work and their limitations or lack of limitation. I propose an Ad Hoc Committee, to be made up of actively practicing members of the House of Delegates plus at least one member of the Composite State Board of Medical Examiners appointed by the Speaker to investigate this new, and to me, controversial allied field of medical service and to report back to the House of Delegates their findings and recommendations one year hence.

This study should include an investigation of those who have already been certified and are now employed and working in Georgia. I have a fear the P.A. program does not have all the built-in safeguards and/or limitations that we, the physicians of Georgia, desire.

I wish to thank every member of the Medical Association of Georgia for allowing me the honor of the Presidency of their organization.

Everyone has been considerate and helpful; even those with complaints or criticisms vented their feelings in a polite and sometimes even sympathetic manner!

MAG is very fortunate in another way. We have the most efficient and competent Headquarters Staff in the entire country and I know this to be true. Without Jim Moffett and his people at Headquarters their assistance would soon falter and many of our functions would immediately cease. We owe them much.

I pledge my continued love and support to the members and officers and staff of the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval with one amendment to the report with highest commendations for Emory Bohler, M.D. When amended, the recommendations would read as follows: "Many members of MAG have expressed a great deal of concern about physicians' assistants; their training, their privileges, their work and their limitations or lack of limitations. Reference Committee proposes an ad hoc committee be made up of actively practicing members of the MAG, one of whom employs a physician's assistant plus at least one member of the Composite State Board of Medical Examiners appointed by the Speaker to investigate this new and, to me, controversial allied field of medical service and to report back to the House of Delegates their findings and recommendations one year hence. This study should include an investigation of those who have already been certified and are now employed and working in Georgia. I have a fear the P.A. program does not have all the built-in safeguards and/or limitations that we, the physicians of Georgia, desire."

HOUSE OF DELEGATES ACTION—Adopted the report of the President as amended by the Reference Committee.

SECRETARY

Earnest C. Atkins, M.D.

As my second year as Secretary nears an end, it continues to be apparent that the activities of the Medical Association of Georgia, both in number and complexity, are rapidly accelerating. The leadership ability of the members, Council, Executive Committee, Committee Chairmen, Headquarters office staff, CHAMPUS staff, EMBRO staff and the staff of the Medical Care Foundation continues to be more and more apparent. It is a genuine pleasure to serve with such dedicated and effective people.

MEMBERSHIP REPORT

	1972	*1973*
Active	3,418	3,465
DE-1	62	63
DE-2	31	21
DE-4	15	10

Life	184	179
Associate	106	111
Service	60	65
Honorary	1	1
Affiliate	1	1
Student	3	1
	3,881	3,917

The membership of the Medical Association of Georgia continued its upward climb during the year 1973. The rate of growth about equalled the previous year. In 1972 we increased our membership: active 35 and total membership, 45. In 1973 we increased our active membership to 3,465 and our total membership to 3,927. Our AMA membership is at an all time high, 3,190 in 1973 as compared to 3,117 in 1972. A net gain of 73. This also offset the losing of 23 AMA members for 1971 with a membership of 3,140. This is a total gain of 50 AMA members over 1971. Estimated number of licensed physicians residing in Georgia as of the end of 1973 was 5,405.

Although we had a good membership year both at the MAG and AMA the big concern to me is the 1,500 of Georgia's physicians that are not members. We should continue to serve our present membership even better and employ the advantages of organized medicine so that all physicians in Georgia will rally to swell our ranks.

At the end of this report, I will make recommendations to increase our membership.

GEORGIA REGIONAL MEDICAL PROGRAM

There will be a separate report by the MAG Coordinator of the Regional Medical Program included in this annual issue of the Proceedings. Although there have been problems in funding the program, there is continued recognition by the federal government of Georgia's leadership in this field under the capable direction of J. Gordon Barrow, M.D., director of the Program.

Your Secretary, in his weekly meetings at the Headquarters Office, has had the opportunity of discussing all aspects of the Georgia Regional Medical Program with Dr. Barrow. Thus, we can deal with problems as they arise, and the liaison helps keep the leadership of MAG and the GRMP staff aware of the activities and thoughts of the other.

Charles Adair, M.D. of Washington, Georgia continues to look after the best interests of the Medical Association in the program of the Georgia Regional Medical Program, and we are all fortunate to have such a dedicated, hardworking physician to represent us as coordinator.

CHAMPUS PROGRAM

The CHAMPUS Program continues as a good operation and the Department of Defense, the physicians and the patients all seem well pleased with the manner in which this program has been conducted over the years. Mrs. Joyce Butler, CHAMPUS administrator and her staff are to be commended. During 1973, there was

GEORGIA 1973

CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE UNIFORMED SERVICES
STATISTICAL REPORT

Claim Flow	Annual 1972	Annual 1973	Percent Totals 1972	Percent Totals 1973	Average Per Month 1972	Average Per Month 1973	Average Per Day 1972	Average Per Day 1973	Percent of Annual Increase or Decrease 1972	Percent of Annual Increase or Decrease 1973
I. No. Claims Received										
1. Inpatient*	30,954	28,413	42.9	37	2,579.5	2,367.8	122.35	113.2	4.88 +	8.2–
2. Outpatient*	30,903	38,480	42.8	50	2,575.3	3,206.6	122.15	153.3	38.9 +	24.5+
3. Drugs†	10,271	9,746	14.3	13	855.9	812.2	40.59	38.8	85.63 +	5.1–
Total	72,128	76,639	100	100	6,010.7	6,386.6	289.09	305.3	25.88 +	6.3+
II. Returned	8,439	9,698	11.7	12.7	49.66	830.7	33.36	38.7	17.96 +	14.9–
III. Rejected	6,794	9,225	9.4	12	36.83	768.8	26.85	36.8	28.02 +	35.8+
IV. Review Committee	102	84	.001	.001	4.2	7	.4		67.21 +	17.6–
V. Number Claims Paid										
1. Regular	45,328	47,865	75	73	3,777.3	3,988.7	179.16	190.7	10.505+	5.6+
2. Handicap	1,025	878			85.4	73.2	4.05	3.5	3.302–	14.3–
3. Drugs	6,911	7,212	67	74	575.9	60	27.32	28.7	48.62 +	84.4+
Total	53,264	55,955	73.8	73	4,438.7	4,662.9	201.53	222.9	13.98 +	5.1+
VI. Funds Disbursed										
1. Regular	$4,317,461.76	$4,744,568.24	88.4	89.7	$359,788.48‡		$395,380.69§		0.83 +	9.9+
2. Handicap	363,552.38	317,971.92	7.5	6	30,296.03		26,497.66		1.09 –	12.5–
3. Drugs	201,293.17	226,957.00	4.1	4.3	16,744.43		18,913.08		28.34 +	12.7+
Total	$4,882,307.31	$5,289,497.16	100	100	$406,858.94		$440,791.43		0.73 +	8.3+
VII. Funds Disbursed per Claim										
1. Regular	95.25	99.12								4.1+
2. Handicap	354.68	362.15								2.1+
3. Drugs	29.13	31.47								8 +
Total	91.66	94.53								3.1+

* Includes Handicap
† Consolidated Reimbursement and Vendor
‡ Average per month—1972
§ Average per month—1973

an increase in claim value 6.3 per cent. There was 17.6 per cent decrease in 1973 over 1972 in the number of claims referred to the Review Committee. Your attention is called to the accompanying chart which reveals a rather substantial increase in all aspects of claim processing as handled by the CHAMPUS Program during 1973, particularly the out-patient volume, which are the more time-consuming claims. MAG is one of four state medical associations that serve as the fiscal agent for the CHAMPUS Program.

With increase in activity there is as ever increasing need for more space, and this is being dealt with on a temporary basis.

MAG FOUNDATION

The MAG Foundation (benevolent) grows continually. The bank balance as of December 31, 1972 was $8,411.66. As of December 31, 1973 increased to $10,381.47.

There is included in MAG's annual budget $1.00 per dues-paying member to be allocated to the Foundation in order that a fund may be established to assist indigent physicians and physician's widows.

Again the Foundation expresses its gratitude to the various county society woman's auxiliaries for their numerous contributions to the Scholarship Fund administered by the Foundation.

The activities of the Foundation are governed by a six man Board of Trustees. The current Board and the expiration date of their terms is as follows:

John T. Mauldin, M.D.—1973
Earnest C. Atkins, M.D.—1974
J. Winston Huff—1975
James M. Moffett—1976
Charles R. Andrews, Jr., M.D.—1977
J. Rhodes Haverty, M.D.—1978

WATS LINE (1-800-282-0224)

This toll-free telephone service has been another link between the membership and the Headquarters Office. Even the most skeptical in the beginning are now its most staunch supporters. This speaks for itself.

EMCRO

The Experimental Medical Care Review Organization has given a detailed report separately but the fine spirit of cooperation between the project director, Lowell Foster, and his staff, with MAG deserves attention and commendation.

GEORGIA MEDICAL CARE FOUNDATION

Again a separate report is given, but the fine spirit of cooperation between the Executive Secretary, Mr. Gus Anderson, and his staff, with MAG deserves attention and commendation.

HEADQUARTERS OFFICE

The Headquarters Building continues to serve as a cramped (spacewise) but adequate focal point for the operations of the Association. With every segment of operation growing, expansion is the word of the day.

Our Headquarters office staff is continually growing in response to an enlarged membership and a vast number of projects and activities. The total personnel at MAG in the various related activities that are sponsored by MAG is 118. A breakdown of the personnel by department is as follows:

	1972	*1973*
GRMP	40	27
CHAMPUS	15	18
MAG	15	18
EMCRO	12	22
GA. MEDICAL CARE FOUNDATION	16	33
	98	118

There continues to be a turnover of personnel in the MAG headquarters office. New additions to the secretarial staff include Lynn Pearson, Lynn Phipps, Kris Birkness and Cathy Oliver in spite of the fact that 25 of the 80 MAG employees are new. The total combined length of service as of March 1973 was 43 months. The cost of the operation of the Headquarters Office was approximately $30,000 per month. The programs and projects of MAG continued to function smoothly and in a manner that reflects credit on the profession and its Association.

May I remind the House that one of its distinguished Delegates, John P. Heard, M.D. of the DeKalb County Medical Society, is running for a post on the AMA Board of Trustees. We are proud of John for this ambitious undertaking and we should work hard for his success.

RECOMMENDATIONS

Expanding membership is a vital concern of MAG as well as to our component medical societies. Accordingly, I would like all road blocks removed to assure increased membership.

(1) Change Constitution and By-Laws to permit AMA members transferring from another state medical association to join MAG without additional dues when out-of-state dues are currently paid.

(2) Change Constitution and By-Laws to allow reinstatement of delinquent members by approval of county medical society and payment of current dues.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends approval and commendation of the report of the Secretary with acknowledgement of the clarity and completeness of this report and are in full agreement that continued membership is the key to the Medical Association of Georgia's expansion in the future.

HOUSE OF DELEGATES ACTION—Adopted the report of the Secretary.

COMMITTEE ON CONSTITUTION AND BYLAWS

John T. Mauldin, M.D.

ITEM 1: Past presidents as honorary members of Council and AMA alternate delegates as ex-officio members of Council.

At the 1973 House of Delegates meeting, amendments to both the Constitution and Bylaws were proposed that would enlarge the Council by making all past presidents of MAG, as well as all AMA alternate delegates, ex-officio non-voting members of the Council. Specifically, Article VI, Section 1 of the Constitution

would be amended by adding the above-mentioned individuals so that Article VI, Section 1 would then read:

"SECTION 1. COMPOSITION. Council is composed of the president, the president-elect, the immediate past president, the two preceding immediate past presidents, two vice-presidents, secretary, treasurer, speaker of the House of Delegates and councilors as provided for in the Bylaws. Delegates *and alternate delegates* to the AMA, editor of the *Journal, past presidents other than the three immediate past presidents* and the executive director shall be ex-officio members of Council without the right to vote. Vice-councilors shall be ex-officio members except in the absence of their respective councilors as provided for in the Bylaws. The vice-speaker shall be an ex-officio member except in the absence of the speaker as provided for in the Bylaws."

Chapter IV, Section 1 of the Bylaws would be amended by adding to the last paragraph of said section, "Past presidents and AMA alternate delegates as ex-officio, non-voting members of Council," so that said paragraph would then read:

"Vice-councilors shall be ex-officio members of Council without the right to vote except in the absence of their respective councilors when they shall serve as councilors. The vice-speaker shall be an ex-officio member of Council without the right to vote except in the absence of the speaker when he shall serve in the speaker's stead. Delegates *and alternate delegates* to the American Medical Association, the editor of the *Journal, past presidents and other than the three immediate past presidents* and the executive director shall be ex-officio members of Council without the right to vote."

These amendments were properly received by the House of Delegates at the 1973 session; have lain on the table for a full year, and are now eligible for final action by the House of Delegates.

ITEM 2: Interspecialty Council Delegates

The 1973 House of Delegates amended the Bylaws to create an Interspecialty Council composed of a defined group of specialty society representatives. In addition, it provided that the chairman of the Interspecialty Council would be a full, voting member of the MAG Council and that each specialty society represented on the Interspecialty Council would be authorized to elect a delegate to the MAG House of Delegates with the respective specialty society presidents serving as alternate delegates.

Although the House of Delegates adopted amendments to the Bylaws necessary to accomplish the above objectives, they cannot be implemented until the Constitution is also amended so that the Bylaws will not be in conflict with the Constitution. The appropriate constitutional amendments could not be voted on last year as they must lie on the table for a year before they can be enacted.

The following constitutional amendments were received at the 1973 session of the House of Delegates. They were found to be in order by the Reference Committee and are presented here for ratification by the 1974 House of Delegates.

Constitutional Amendments

ARTICLE V, SECTION 1: Amend Article V, Section 1 of the Constitution by deleting the first sentence in its entirety and inserting in lieu thereof the following: "The House of Delegates is composed of delegates elected by component county medical societies *and the specialty societies* as provided in the bylaws."

ITEM 3: Delete verbiage re collection of additional dues

Chapter VIII, Section 2, Paragraph 3 provides for the payment of $100 additional dues levied by the House of Delegates in 1969 which were payable and past due as of September 15 of that year. In view of the fact that it was not necessary for this to be in the Bylaws in the first place, plus the fact that the due date for these additional dues is now almost five years past, it is recommended that Paragraph 3, Section 2 of Chapter VIII BE DELETED.

ITEM 4: Bylaws Change affecting payment of dues in arrears as a condition for membership reinstatement

Council approved the submission to the House of Delegates of an amendment to Chapter VIII, Section 2 of the Bylaws empowering the Executive Committee of Council to excuse the payment of dues in arrears as a condition for the reinstatement of lapsed membership.

Specifically, it is recommended that Chapter VIII, Section 2 be amended by adding the following phrase to the last sentence of said section: "; provided, however, that Executive Committee of Council is authorized to excuse the payment of any dues in arrears but not dues for current year as a condition of reinstatement to membership terminated during any prior year for failure to pay dues or additional dues."

The above would then designate the paragraph beginning "An active member who fails . . ." as paragraph (3), as the previously designated paragraph (3) has been delected in its entirety.

ITEM 6: Membership dues payment exceptions

The following amendment is offered in response to a request by Council to excuse from the payment of the current year's dues those physicians transferring their practice to Georgia from another state, provided they were dues-paid members of the state medical association in that state.

Chapter VIII, Section 2(A) is hereby amended by adding the following sentence at the end of said Section 2(A):

"A physician transferring to the Medical Association of Georgia from another state medical association shall be excused from paying current dues provided that he has paid all dues to the state association from which he has transferred."

ITEM 7: Approval of Constitution and Bylaws of county medical societies

Your committee has reviewed the Constitution and Bylaws of the Whitfield-Murray, Bibb and DeKalb County Medical Societies and, after suggesting minor changes, these documents have been approved by the Council. This is for the information of the House of Delegates and requires no action.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee considered each item of the Constitution and Bylaws report separately and makes the following separate recommendations:

Item 1—Composition. Your Reference Committee recommends approval of Item 1 in its entirety.

Item 2—Interspecialty Council delegates. Your Reference Committee recommends approval of Item

2 with the knowledge that this will increase the number of delegates reporting to the House of Delegates, but with this increase it is anticipated a closer unity to the Medical Association of Georgia by the specialty societies.

Item 3—Delete verbiage "re collection of additional dues." Your Reference Committee recommends approval of Item 3 in its entirety.

Item 4—Bylaws change affecting payment of dues in arrears as a condition for membership reinstatement. Your Committee recommends approval of Item 4. Amendment to renumber in proper form after Item 4—Items 5 and 6.

Item 5—Membership dues payment exceptions. Your Reference Committee recommends approval of Item 5 with anticipation of more physicians moving to our great state and becoming involved in our Association as soon as possible.

Item 6—Approval of Constitution and Bylaws of county medical societies. Your committee recommends approval of Item 6 that the Constitution and Bylaws of Whitfield-Murray, Bibb and DeKalb County Medical Societies which have been approved by Council and need no action by the House of Delegates.

HOUSE OF DELEGATES ACTION—Adopted Items 1, 3, 4, 5 and 6 of the Constitution and Bylaws Committee report, but disapproved Item 2 which authorized delegate representation from the specialty societies who hold membership on the Interspecialty Council.

SUPPLEMENTAL REPORTS OF THE CONSTITUTION AND BYLAWS COMMITTEE

John T. Mauldin, M.D., Chairman

Amend Chapter I of the Bylaws by adding thereto a new section to be known as Section 15, which shall read as follows:

"15. A person who was accepted as a member in good standing as of May 12, 1974, shall continue as a member of this Association notwithstanding he may not hold the literal degree of Doctor of Medicine or Bachelor of Medicine; provided, however, that such member shall be subject to all other provisions of these bylaws for continuation of membership."

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of Supplemental 74-6 and fully understands the problem of foreign medical graduates and urges its support and the support of the entire membership of the Medical Association of Georgia and early rectification of this problem.

HOUSE OF DELEGATES ACTION—Adopts Supplemental Report 74-6 of the Committee on Constitution and Bylaws.

Amend Section 3, Chapter IV, of the Bylaws as follows:

Strike the third sentence of Section 3, Chapter IV and insert in lieu thereof the following new sentence:

"The second vice-president and the speaker of the House of Delegates, or, in his absence, the vice-speaker, shall be ex-officio members of the Executive Committee; however, only the speaker or, in his absence, the vice speaker, shall have the right to propose motions and to vote."

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee considered extensively this report along with the previous reports and recommends its approval in its entirety.

HOUSE OF DELEGATES ACTION—Adopted Supplemental Report 74-7 of the Committee on Constitution and Bylaws.

SPEAKER OF THE HOUSE OF DELEGATES

Harrison L. Rogers, Jr., M.D.

There are few positions in MAG which offer an opportunity for prolonged service to the physicians of Georgia. One of these is the job of speaker of the House. I have enjoyed serving you first as vice speaker under Frank Walker, then as speaker for the past six years. The minor parliamentary problems which developed were in most cases easily resolved because the House is basically a large group of people with identical aims and ideals. This group of doctors, our delegates, are fair and just and demand for their protagonists and antagonists fair and just treatment. It has been a simple matter to translate the will of the House into Actions of the House because of this eminently fair attitude on the part of our members.

As speaker it has been my privilege to meet with both Executive Committee and Council and I feel that the presence of a representative of the House is an asset to both these bodies. The Bylaws which deny your speaker a vote in the Executive Committee is a detriment. With the long tenure available to the speaker, his vote and complete participation in the deliberations of the Executive Committee would be, I believe, an asset.

During my period of service our sessions have gone from a three day meeting to a four day meeting and now back to a three day session. In addition, this year the scientific portion has been completely divorced from the business session by action of the House in Augusta last year. I believe that this will prove to be a wise decision by the House, for attention to the concurrent deliberations of the House and the scientific program frequently detract from both. Certainly, it is wise to review and reevaluate both these functions on a periodic basis with revisions made as necessary.

RECOMMENDATIONS

It is recommended that your new speaker be granted the right to make motions and vote in Executive Committee. The Committee on Constitution and Bylaws should be instructed to prepare such changes for consideration next year.

Thank you for the opportunity of serving you.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of this report and offers highest commendation to Harrison L. Rogers, Jr., M.D., for a stupendous job well-done as speaker of the House of Delegates.

HOUSE OF DELEGATES ACTION—Adopted the report of the Speaker of the House.

CHAIRMAN OF COUNCIL

David A. Wells, M.D.

I have enjoyed the honor and privilege of chairman of Council for this second year.

I have attended all Council meetings and all Executive Committee meetings except one. The MAG staff members continue to do an excellent job and should be commended for their efforts.

RECOMMENDATIONS

In my report last year I made several recommendations. The House of Delegates acted on these and formed an Ad Hoc Committee on Organization and Functions of the MAG. I was appointed chairman of the Committee. The report of the Committee is filed separately. The purpose of this Committee has not been fulfilled. The recommendations I made last year are still valid. The tremendous impact of PSRO on MAG is obvious to all. Efforts to make long-range plans and recognization have had to be put aside. I hope during this next year this pressure will be lightened so that the other aspects of the MAG will get the attention that they deserve.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of this report with one grammatical change in the next to the last sentence, which should read "The tremendous impact of PSRO on MAG is obvious to all. Efforts to make long-range plans and reorganization have had to be put aside."

HOUSE OF DELEGATES ACTION—Adopted the report of the Chairman of Council with the editorial change of the Reference Committee report.

AD HOC COMMITTEE ON ORGANIZATION AND FUNCTIONS

David A. Wells, M.D.

The Ad Hoc Committee on Organization and Functions was appointed last summer pursuant to a recommendation by the 1973 House of Delegates. The House recommendation stipulated that the Committee be comprised of seven members, three from Council and four from the membership-at-large. It was obvious from the composition prescribed that the House did not want the views of the Committee or its ability to recommend significant change to be inhibited in any way.

The Committee met in October and agreed generally on a list of priorities to be considered and assessed. These included: (1) appropriate areas of jurisdiction for the Council, Executive Committee and staff; (2) proper relationship between MAG and any satellite organization created or activity authorized by MAG; (3) an expanded set of Association purposes; (4) membership services; (5) relationship with (a) specialty societies, (b) medical schools, (c) hospital medical staffs, (d) residents and interns, (e) medical students; (6) a study of MAG operations; and (7) county medical society and district medical society organization.

Subsequently the Committee considered the matter of an expanded list of Association purposes which it has approved and recommends to the House of Delegates for adoption. (See Recommendations)

The Committee is exploring ways and means by which a full range of administrative services may be offered by MAG to the specialty societies that comprise the Interspecialty Council. Although financing and space present two imposing obstacles, there is nonetheless optimism that some meaningful and needed services can be provided.

The Committee is directing its attention to such services as:

1. Space in the headquarters building complete with separate filing facilities for each group,
2. Staff assistance for conventions, seminars and business meetings,
3. Central billing of dues and assessments when requested by each specialty group,
4. Accounting and auditing services when requested,
5. Legal advice and analysis of laws and regulations,
6. Coordination of MAG committee activity with specialty society committee activity,
7. Act as a depository and disbursement agent under direction of the specialty groups secretaries and treasurers,
8. Provide a permanent address and a permanent home from which to conduct business.

The Committee will continue to study and consider each of the priorities enumerated above. Subsequent reports to Council, as well as to the House of Delegates, making recommendations affecting the structure and function of MAG are anticipated.

RECOMMENDATIONS

The purposes of the Medical Association of Georgia are to promote the science and art of medicine and the betterment of public health. It is recommended that the following statement setting forth the means by which those purposes may be achieved be adopted and become a part of the expanded purposes of MAG:

1. Establish the federation of organized medicine through the chartering of constituent county medical societies within Georgia and by joining with similar state medical associations constitute the American Medical Association.
2. Promote the provision of quality medical care at reasonable cost with fair remuneration to the physician.
3. Encourage the maintenance of the physician-patient relationship as an essential in the delivery of quality medical care.
4. Seek to assure all Georgians access to quality medical services regardless of their financial condition, geographic location or sophistication in using the health care system.
5. Advance the scientific, socio-economic and medical-political knowledge of the profession so that the members may better serve their patients, their community and their association.
6. Maintain the highest standards of professional conduct and adhere to the principles of medical ethics set forth by the AMA.
7. Support reasonable expansion of the number of persons entering the medical and allied health professions as well as assure that the best qualified individuals are admitted into the professions in order to meet the established needs for such manpower in Georgia.
8. Reinforce recognition of an ongoing, life-long need for continuing medical education in the art and

science of medicine through participation in programs of continuing education.

9. Establish and provide specific services to the membership which meet their needs.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee considered this report in its entirety and recommends its approval.

HOUSE OF DELEGATES ACTION—Adopted the report of the Ad Hoc Committee on Organization and Functions.

COMMITTEE ON QUACKERY

James A. Kaufmann, M.D.

Your Committee on Quackery continued the battle of informing the public and the members of the Georgia General Assembly of the dangers of the chiropractic cult and other non-medical cults which endanger the health of all Georgians.

After last year's overwhelming defeat in committee of House Bill 147 (Chiropractic Insurance Equality Bill), the chiropractic profession remained relatively quiet during the 1974 General Assembly. No additional bills were introduced by the chiropractors. However, amendments were offered to other legislation but were overwhelmingly defeated.

Chiropractors tried to amend Senate Bill 153 (Dental Surgery Bill) to include all practitioners of the healing arts—chiropractors, chiropodists, dentists, medical doctors, registered nurses, practical nurses, optometrists, osteopaths, pharmacists, veterinarians, naturopaths, physical therapists and psychologists. However, the amendment used only the words "practitioners of the healing arts" and was overwhelmingly defeated by a voice vote.

This was the only legislative attempt made by chiropractors this year, but I am sure another attempt will be made in 1975 with a new legislature to pass the chiropractic "Freedom of Choice" insurance bill.

House Bill 699, "Professional Healing Arts Licensure," was withdrawn at MAG's request at the beginning of the legislature. This bill which would only affect chiropractors would require anyone who applies for a Georgia license to practice either dentistry, medicine, optometry, osteopathy, podiatry or chiropractic to be a graduate of an accredited school recognized by the National Commission on Accrediting or the U. S. Department of Health, Education and Welfare. At present there is a loophole in a federal law which tends to confuse this issue. Once this is straightened out, this bill will be introduced again and every member of MAG will be asked to help seek its passage.

Although chiropractic reigns as the major quackery problem in Georgia, there are others about which the public, as well as the Georgia Legislature, needs to be informed. These are the objectives of your Committee on Quackery.

RECOMMENDATIONS

Your Committee recommends that the Committee on Quackery be continued and that it continue to lead the entire medical profession in efforts to combat the spread of chiropractic; and that all available support be given to any legislation that will curb the activities of chiropractors and other health quacks in Georgia.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of this report with highest commendation for James A. Kaufmann, M.D. who has spent diligent time, hours, effort and personal sacrifice to combat the works of health quacks and chiropractors which is a never-ending battle in Georgia as well as the country.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Quackery.

RESOLUTION 74-3 CREATION AND PROCUREMENT OF QUALIFIED FAMILY PHYSICIANS

Stephen C. May, Jr., M.D.

WHEREAS, At least 80 per cent of inquiries to the Cobb County Medical Society entail requests for a family physician, and

WHEREAS, It is our impression that a similar condition exists throughout the State of Georgia, and

WHEREAS, It is felt that much of the medical needs of the people of Georgia related to inadequate numbers and distribution of primary physicians, and

WHEREAS, The primary interest of MAG is the health of the people and the best and most economical provision for its distribution to the people of Georgia,

THEREFORE BE IT RESOLVED, That the MAG support, encourage and indeed give its highest priority to the creation and procurement of qualified family physicians to augment the medical care now available to Georgians, and

BE IT ALSO RESOLVED, That the deans of the two Medical Schools be apprised of these needs and aims of the MAG, and

BE IT ALSO RESOLVED, That these needs and aims be made known to the Governor of Georgia and its legislature in order that sufficient funds might be made available to help provide for the education and procurement of more family physicians in our state.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of the recommendation of Resolution 74-3 through the first "RESOLVED" and offers the following changes to read as follows: "BE IT RESOLVED that the highest commendation and appreciation be given to the Georgia Board of Regents and the Medical College of Georgia for having the foresight and stamina to break down all barriers to construct and institute a Department of Family Practice under the guidance and direction of William E. Lotterhos, M.D. BE IT ALSO RESOLVED that the Medical Association is unanimously in favor of all existing and all future medical training facilities actively participating in the training of family practitioners and BE IT ALSO RESOLVED that the secretary of the House of Delegates be instructed to send a copy of this resolution to the Georgia Board of Regents, dean of the Medical College of Georgia and William E. Lotterhos, M.D."

HOUSE OF DELEGATES ACTION—Adopted Resolution 74-3 as amended by the Reference Committee.

SUPPLEMENTAL REPORT OF COMMITTEE ON EDUCATION

Nicholas E. Davies, M.D.

Because of the importance of early involvement of young physicians in the affairs of organized medicine, last year the House of Delegates approved full voting membership for interns and residents. I believe that this policy should be expanded so that we can involve the future physicians as early as possible in our county medical societies, MAG, and the AMA.

RECOMMENDATIONS

I would recommend that the Bylaws of MAG be changed so that:

1. Medical students be allowed full membership status including the right to vote, hold office, and receive MAG publications.
2. Student membership dues to MAG be set at $10 per annum.
3. The SAMA Representatives from MCG and Emory be given full voting privileges in the House of Delegates.
4. These recommendations be referred to the Constitution and Bylaws Committee for development of appropriate amendments so that they may be considered at the next Annual Session of this House of Delegates.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of this report with one change in Number 1 which would read as follows: "Medical students be allowed a non-voting membership status including receiving all MAG publications" and your Reference Committee recognizes the need for additional MAG membership and hopes MAG will solicit medical students to participate in the functions if possible for they are future delegates.

HOUSE OF DELEGATES ACTION—Following considerable debate, it was moved, seconded and approved that this report be tabled for the duration of this session of this House of Delegates.

SECOND VICE PRESIDENT

Luther M. Thomas, M.D.

As your second vice president, I have attended as many meetings of Council and Executive Committee of Council as possible. I joined other members of the Executive Committee in the Washington visitation to discuss PSRO with our legislators. This year, as a novice, has been enjoyable and enlightening. I appreciate the honor of serving the members of MAG.

The position of second vice president lacks a prestigious quality which may detract well-qualified candidates. That quality is the lack of privilege of making motions and voting in Executive Committee sessions unless the first vice president is absent. I feel that according this privilege to the second vice president would embellish the position with some authority and attract the interest of qualified candidates, and increase the representation of the membership on the Executive Committee.

RECOMMENDATIONS

The second vice president be accorded the privilege of voting and making motions in all Executive Committee sessions by making the necessary changes in the Constitution and Bylaws of MAG.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee considered this report and recommends unanimous disapproval of the Officers Report 74-23 knowing the size and the complexity of the already existing Executive Committee.

HOUSE OF DELEGATES ACTION—Adopted the report of the Reference Committee thus disapproving the report of the second vice president.

SUPPLEMENTAL REPORT OF COMMITTEE ON STATE LEGISLATION

Harrison L. Rogers, M.D.

As an addition to the formal legislative report, I feel that special cognizance should be given MAG's legislative representative, Mr. Rusty Kidd. Due largely to his efforts we had excellent communication between our physicians and their legislators, with the good results already noted in the formal report. This was accomplished by the excellent "News Letter" which was sent out during the session along with numerous personal contacts. In this task Mr. Kidd was aided by Mr. Wallie Carpenter and Mr. Carl Bailey.

Mr. Kidd also represented our interests extremely well in committee hearings as well as by individual contacts with the state legislators. He has also served well as liaison between MAG and the Woman's Auxiliary in addition to other Allied Health organizations. In general Mr. Kidd deserves our sincere appreciation for a job well done.

I would also like to thank those MAG members who participated in the "Doctor of the Day" program. The legislators appreciated their efforts and I am certain that relations between the legislator and his own personal physician were improved in each instance. For those who did not participate, please sign up early for a day at the Capitol next year; this is an enlightening and educational experience which you can ill afford to miss.

This year presents an unusual opportunity for MAG members to offer for political office, for there are many seats in both the House and Senate in which the incumbent has decided not to run again. We have had excellent physician representatives in the past, but in the current General Assembly we have no doctors. This has been a loss to the state, for each of you has the special credentials for service that are unavailable in any other group, in addition to which having a member of either the House or Senate would provide your Legislative Committee with a better opportunity to effect legislative proposals. Please give this special consideration in the next few weeks and contact Mr. Kidd for additional information.

The following is a list of bills which passed the Georgia General Assembly this year that Governor Carter vetoed and *his* reasons. (Refer to Committee Report 74-22.)

Hospital Authority—to clarify meaning of term "Project" (H.B. 1419):

"H.B. 1419 would have allowed hospital authorities to use public funds to build doctors' offices. Most doc-

tors can well afford to pay for the construction of their own offices. To use public funds or patient charges for this purpose would be an improper use of the taxpayers' money."

Pharmacists, Pharmacy and Drugs, Information on Prescriptions (S.B. 613):

"S.B. 613 would have further restricted the right of nurses to prescribe drugs. This would have additionally overloaded our already inadequate number of medical doctors without any demonstrable increase in the quality of medical care."

PSRO—Professional Standards Review Organization (S.R. 301):

"S.R. 301 urges Congress to repeal the law creating the Professional Standards Review Organizations. Repeal of this act would eliminate all controls on the costs of needed medical services."

It is obvious from these vetoes that the Medical Profession in Georgia needs a more receptive Governor. It is up to you—a Georgia physician—a Georgia citizen—a member of MAG—to actively endorse and support a gubernatorial candidate for 1974 that has a responsive attitude toward the health care of all Georgians and toward organized medicine.

RECOMMENDATIONS

1. Commendations to the Executive Committee of MAG on behalf of Mr. Rusty Kidd for a job well done.
2. By notice in the Officer's News Letter—encourage MAG members to offer for elective office.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval with commendation of this report.

HOUSE OF DELEGATES ACTION—Adopted Supplemental Report 74-4 as recommended by the Reference Committee.

RESOLUTION 74-6
MEDICAL INFORMATION PROVIDED TO CREDIT BUREAUS

David A. Wells, M.D., Chairman, for the MAG Council

WHEREAS, privileged medical information is being provided to credit investigation bureaus, and

WHEREAS, this information can be utilized to the detriment of the individual about which it is provided and

WHEREAS, persons about which such information is provided are unaware of the uses to which it may be put, now therefore be it

RESOLVED, that the MAG in cooperation with the credit agencies and the insurance industry develop a form that will guarantee the assurance that a person signing a medical information release form is giving informed consent for the release of the information, and be it further

RESOLVED, that the inquiring agency assure that information is used only for the specific purpose for which it was obtained and for no other purposes.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee, with no knowledge of this problem before this meeting, now recognizes and understands the existing problems therefore recommends approval with highest commendation of Resolution 74-6.

HOUSE OF DELEGATES ACTION—Approved adoption of Resolution 74-6: Medical Information Provided to Credit Bureaus.

RESOLUTION 74-8
MAG SUPPORT OF AMPAC

J. Dan Bateman, M.D., Chairman

WHEREAS government encroachment into the private practice of medicine increases daily at all levels of government, and

WHEREAS, there is an ever increasing need to elect candidates to political office whose beliefs reflect those of physicians and represent the free enterprise system of health care delivery, and

WHEREAS, more and more physicians are seeking PAC dollars for candidates at all levels, and

WHEREAS, GaMPAC can only meet these demands through increased memberships and dues monies;

THEREFORE, BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia go on record favoring the following:

1. Every member of this house become a dues paying member of GaMPAC,
2. Strongly recommend that every member of the Medical Association of Georgia and Auxiliary members become dues paying members of GaMPAC,
3. Urge the Executive Council and all state and county leadership of the Medical Association of Georgia to become sustaining members of GaMPAC, and be it further

RESOLVED, that the Medical Association of Georgia delegates to the American Medical Association House of Delegates introduce a similar resolution at the next Annual Meeting of the American Medical Association House of Delegates and actively work for its passage in support of AMPAC so as to enhance medicine's political activities on the national level.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends unanimous approval of Resolution 74-8 as amended so to read as follows:

WHEREAS, government encroachment into the private practice of medicine increases daily at all levels of government and

WHEREAS, there is an ever-increasing need to elect candidates to political office whose beliefs reflect those of physicians and represent the free enterprise system of health care delivery and

WHEREAS, more and more physicians are seeking PAC dollars for candidates at all levels and

WHEREAS, GaMPAC can only meet these demands through increased membership and dues monies;

THEREFORE BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia go on record urging and strongly recommending the following:

1. Every member of this House become a dues-paying member of GaMPAC,

2. That every member of the Medical Association

of Georgia and Auxiliary members become dues-paying members of GaMPAC,

3. The Executive Council and all state and county leadership of the Medical Association of Georgia to become sustaining members of GaMPAC and

BE IT FURTHER RESOLVED that the Medical Association of Georgia delegates to the American Medical Association House of Delegates introduce a similar resolution at the next annual meeting of the American Medical Association House of Delegates and actively work for its passage in support of AMPAC so as to enhance medicine's political activities on the national level.

HOUSE OF DELEGATES ACTION—Adopted Resolution 74-8: MAG Support of AMPAC as amended by the Reference Committee.

Chairman Clark expressed his appreciation to the members of the Reference Committee for their time and effort and moved that the Report of the Reference Committee be adopted as a whole as amended. This motion was duly seconded and approved.

REPORT OF REFERENCE COMMITTEE C

William C. Waters, III, M.D., Chairman

Chairman Waters reported to the House of Delegates that the reports and resolutions referred to Reference Committee C had been considered by the committee which met at 1:00 p.m. in the North Ballroom, Pulaski Room and the James Madison Room of the DeSoto Hilton Hotel in Savannah, Georgia, on May 10, 1974. Members of the committee present included William C. Waters, III, M.D., Atlanta, chairman; L. A. Flint, M.D., Canton, vice chairman; Joseph M. Almand, M.D., LaGrange, J. Kenneth McDonald, M.D., Augusta; James J. Oosterhoudt, M.D., Dalton.

PRESIDENT-ELECT'S SPEECH

J. Rhodes Haverty, M.D.

I would like to share some of my thoughts with you about three basic themes. The first is reflections of the past; the second that of assessment of the present; the third that of concerns for the future. I shall approach these initially from a personal point of view, and then more specifically related to the Medical Association of Georgia.

When one has certain bench marks in his life, as this occasion is for me, he tends to reflect, and in doing so, looks back for guidance from the past. I did that, and reinforced a fond memory when I came across the president-elect speech delivered to this house 10 years ago. That address came from one of the master story-tellers of this state, Dr. J. G. McDaniel, who was our president-elect in 1963-64. It was this illustrious man who first got me interested in running for office in the Medical Association of Georgia, when he suggested that I run for the position of secretary in 1966.

My six years as secretary, and one year as your vice speaker, culminated for me last year in Augusta in a hotly contested election, when you chose me for your president-elect. I am honored by your support and grateful for your trust, and will try to merit it, particularly during this next year as your president, but whenever I am called upon to serve this august Association.

One convenient and appropriate approach when taking over the helm of an organization is to outline specific and subsidiary goals to be achieved in the coming year. This is the mark of a leader. Nevertheless, I would like to depart from this approach, and simply reflect, assess, and project on several different subjects.

One fortunate thing about our democratic and representative form of government in the Medical Association of Georgia is the diversity of interests of its membership. This is bound to be reflected in the leaders that are chosen. When looked at over the long haul, emphasis on various issues that outline the interests of those chosen to lead makes for a more vigorous and responsive organization. As most of you know, my main interests have been and continue to be in the general field of education, particularly in medical education, but also including the educational preparation of nurses and allied health personnel. Issues relating to educational program accreditation and personal credentialing of all sorts (such as licensing, certification, registration, etc.) are all a part of these interests. Naturally I am concerned about many other things as they relate to our profession, and to the Medical Association of Georgia, but it is important that varied specific areas of interest be emphasized from time to time so that the final total pattern will make for a more comprehensive organization because of the diversity of its leaders.

One of the great problems of our organization, and of all organizations, is that of communication. Communication is the key for the success of any endeavor when one group of individuals attempts to act for another, such as when a smaller group like we are here acts for a larger one, like the entire MAG. Participation and input from the membership is a necessary component of proper communications, and this input *from* the membership as it is *reflected* by the leaders is the key to the understanding of the organization *by* the membership.

One of our component societies recently editorialized in its newsletter some comments concerning raising its fees. The questions asked basically related to whether the county society should be cut down on the activities of the society, or should request more activity from those already intimately involved in the society, or should increase dues to pay more staff to do the work required because of the low level of participation by the membership. Sometimes members of an organization may expect too much of the organization—too much of the organization without the personal involvement of the individuals themselves—the "let George do it" syndrome. Here communication begins to break down—participation and input *from* the membership is lacking, the membership doesn't understand the leaders because the leaders cannot reflect properly the wishes of the membership at large, and the whole system begins to weaken.

On reflecting on this editorial, I recalled a portion of an article I wrote for the *JMAG* four years ago when I stated that the fee-for-service method of paying physicians must continue because the dedication and talent needed for the demands of day-to-day practice required this form of compensation as opposed to that of

a salary alone. However, I stated that a corollary of that point had to be made: that those *practicing* physicians would have to relinquish some of the prerogatives of planning how medical practice will evolve to those who are salaried, because it is only salaried physicians who have the time and lack of constant pressure to be able to reflect on, to play for, and to promote what a changing society is demanding. Communication, debate, and decisions among our members who represent various groups must take place constantly so that understanding of all points of view may occur, and desirable, effective progress may be made for the Association.

Some thoughts about the future include some concerns of mine, one of which was crystalized in a speech given to the Atlanta Rotary Club during this past year by the president of a major public relations firm in the United States. He was commenting about the national movement, evident to all, of minorities and other heretofore exploited groups learning first that they had been victimized, and secondly that by joining together they could create power for themselves. These observations led to the disturbing recollection that approximately 200 years ago the people of this nation gave permission for certain kinds of activities to take place. This permission was given primarily through legislative acts, judicial decisions, and executive regulations. The activities included such things as the privilege of practicing medicine; the privilege of living where we wish; the privilege of choosing whom we will associate with.

The final point of this address noted that what the public gives permission to do, it also may take away. As I understand how this applies to medicine, it seems clear that we in the medical profession must satisfy the public, or have them understand why our position is correct, or they simply may take away their permission for us to continue to act as we have done in the past.

One final set of personal reflections relate to the AMA Congress on Medical Education held in Chicago in February 1974. One theme kept repeating itself in many speeches by different kinds of speakers. More and more health education, and more and more health services delivery, are becoming interdisciplinary. Individual institutions, or single departments or schools no longer are capable of conducting the kinds of education necessary for our future. Similarly, solo health practitioners can no longer administer the total health services needed in today's America.

One complex problem this causes is that we will have to develop some different mechanism to pay for the services of these diverse people responsible for teaching those who will deliver the health services of tomorrow. We somehow have to involve private practitioners, educators from both public and private institutions, agency personnel of local, state and national governments, and consumers in developing and carrying out this complex process of education. These various individuals will have to be compensated in a manner as yet not worked out. This will bring about major changes in many other fields as well, including taxation and distribution of tax revenues, utilization of groups of people other than by traditional modes, and the acceptance by all of different ways of looking at things and different ways of relating to people.

Let me reflect a bit now on some relatively recent history and progress of the Medical Association of Georgia. A past president of this Association, Dr. George Alexander, in 1965, deplored the decrease in family practitioners, warned that paramedical programs should be developed within the state, but should remain under the direction of physicians, and reemphasized the importance of our continued concern with our own code of ethics. The more things change, the more they are the same thing!

It was only a year later that Past President Walter Brown, from the autonomous state of Chatham, was concerned about the unworkability of bad laws passed by the United States Congress; how communications between the Council of the Medical Association of Georgia and the Board of Public Health was important to continue if we had any hope of maintaining wise control over the health of our citizenry; and deploring the poor attendance at annual meetings. Again, things have not changed much, have they?

During the mid-sixties, however, the leadership of the Medical Association of Georgia was being castigated by many of its delegates for deficit spending. These days have passed, and under Carson Burgstiner's stewardship we are in excellent fiscal condition. In 1968, it was recommended that we overhaul our annual session.

This is being accomplished, and I suspect our annual sessions of the future will be much more effective and productive, whether the attendees choose to be involved in the political and socio-economic aspects of our Association, or wish to take advantage of the scientific programs which will be given separately.

In assessing the Medical Association of the present, one question might be, "How well is the MAG serving the interests of its members?" In projecting this theme, it may be appropriate for us to remember some comments of Dr. Russell B. Roth in his inaugural address as president of the AMA where he discusses the value of a medical association. He points out that since no physician had to belong to one, it was really a wonder that the volunteer medical associations exerted the influence they did. He went on to say, "Certainly the public—whether it recognizes it or not—profits immensely because of the role played by these societies in upholding standards of competence and ethical performance. Equally certain is the fact that physicians who have elected not to participate in organized medicine have profited immensely from its activities even though they have not paid their way."

One of the early medical ethics promulgated in the United States (Percival's Medical Ethics, 1927) stated that, "A profession has for its prime object the service it can render to humanity." Are we as a medical profession serving humanity? Is it not true that if we do not serve society while serving our own members, in the long run we do harm both to our profession and to society as a whole? One of my favorite quotes is related to this theme. It comes from a contemporary of Roger Bacon, Juan Luis Vives, in the sixteenth century. He says, "This is the fruit of all knowledge, this is the goal. Having acquired our knowledge we must turn it to usefulness, and employ it for the common good. . . . We ought therefore not always to be studying but our study must be attuned to practical usefulness in life. Every study is unlimited in itself but at some stage we ought to begin to turn it to the use and advantage of other people."

A fascinating issue of the state medical journal,

California Medicine, was published in December 1973. I would like to devote a little attention toward some themes developed in this issue.

The California Medical Association claims to have become an increasingly effective, social organizational instrument during the past decade. This was accomplished by no longer attempting simply to satisfy the needs of its members, but by becoming a mechanism for the profession to serve humanity.

One theme concluded that current social, economic, and political theory had not found either satisfactory or lasting solutions to the problems of today, nor had the greatly increasing technological advances done so either. It was felt that society was beginning to crumble, with evidence found in all aspects. The theme went on to develop a concept of the interdependence of society as exemplified by a fabric, made up of individual threads which represent medicine, the law, the church, the educational system, the military and police, government, and others. It was noted that none of these weakening threads in the fabric of society had been able to meet the current expectations and needs of the people, and none had been able to cope effectively with the problems of a growing technology and of human interdependence.

The article went on to imply that medicine might be the one thread that could bring this fabric back to a useable whole again. It recognized that medicine had been made a scapegoat recently for much of society's problems, but also recognized equally that medicine and physicians more than any other group still retained their good names, and are trusted by the public in general. The argument continued by stating that some of medicine's responsibilities to society are rooted in the unequaled and authoritative knowledge of medical science. Medicine is society's authority on health and its disorders, and in fact medicine probably represents consumers better than any other group of people (including the so-called consumers) since it is the only knowledgeable group concerned about human ills.

The California Medical Association claims to have begun strengthening the thread of medicine, primarily through a revival of the scientific authority of organized medicine, and the development of a sound data base for medical practice and health care. The first step toward this strengthening role was a conscious abandonment of the role of the Association as merely a physicians' protective association, and simultaneously a recognition of the basic truths that only physicians could really speak for patients, and that what was best for the patient and his health care was always, in the long run, best for the physician in particular and for medicine in general. Once this idea was accepted, the way was opened for the CMA to direct its actions openly and wholeheartedly in the patient and public interest throughout the gamut of scientific, social, economic, political, and governmental areas of activity.

Throughout this issue, articles pointed out that the physician was in the best position to represent the consumer. Repeatedly it stated that true consumers of medical services are patients, and physicians are in a better position to understand the needs of patients than are legislators, labor union leaders, or other consumer representatives whose direct contact with *patients* and their needs is highly limited. It suggested over and over that medical associations should begin to work harder toward an identification of the physician and the medical profession as spokesmen for consumers. This issue is worthy of thorough study by all of us who are leaders and who are concerned about our profession.

RECOMMENDATIONS

1. I have no specific recommendations for this House, but would urge consideration and discussion on several issues. One is concerned with the headquarters office itself. In my report to you as secretary in 1972, I reviewed the growth of our headquarters office over the previous several years. We had moved into our newly enlarged offices in 1969, only nine years after moving to our present site, and were in the process of studying a subsequent enlargement in 1972.

I even said somewhat facetiously at that time that we might have to enlarge again in 1974. The office enlargement did not take place in 1972, and we are again in a situation of having to consider enlargement of existing facilities, the leasing or purchasing of additional facilities, or moving elsewhere and building more adequate facilities in an area less costly. All of these issues will be brought up by others, and I commend your serious attention to them.

2. Again, in 1972, as secretary I brought to the attention of the House the growth of the House itself. Presently we number 184 delegates. This is a growth of 35 delegates or 24 per cent in the past 10 years. Because of the Interspecialty Council representation, we will number 203 members next year. My suggestion two years ago was for the Speaker of the House to appoint a committee that would include the Chairman of the Constitution and Bylaws Committee to study a reallocation of the House and to report back to the next annual session. This suggestion was referred to the Long-Range Planning Committee, which has not functioned effectively, and which was abolished by the Executive Committee this year. Thus no substantive consideration has been given to this subject. An ad hoc Organization and Functions Committee has been established under the leadership of Chairman of Council, David Wells, which would seem an appropriate committee to study this issue. Regardless of how or where it gets studied, however, it is important that we remain an effective governing body, and some sort of reallocation seems necessary and inevitable.

3. Another item of importance brought out poignantly by the January 1974 meeting of Council in my opinion, relates to financing of this Association's activities. It has been traditional that Council is responsible for expenditures of all monies in behalf of the Association. although a discretionary fund was given to the Executive Committee in 1968 at my request as secretary. In addition, a Finance Committee exists, and meets traditionally once a year to set the annual budget. Council is a wise and deliberative body, but it can be swayed by charismatic, persuasive proponents in the heat of emotional debate. It might be better for the House of Delegates, the final governing body of this Association, to set a limit that Council may spend without referring the matter to the Finance Committee for its recommendations. This maneuver would achieve mainly a more reflective and careful review of the monies required, and probably would result in better stewardship of the funds of the Association.

4. One last point for consideration, and I hope to achieve this during my year as president. This idea also was gleaned from the December 1973 issue of the California Medical Association journal. In an article entitled "Where We Stand" were published some 17 policy position papers of the California Medical Association on such issues as abortion, cost-of-care, health quackery, physician unions, etc. I will attempt during this coming year to bring together such a group of policy statements of the Medical Association of Georgia that have been issued in the past, and would hope that once brought together, these could be updated from time to time as appropriate.

I would anticipate that proper references would appear at the end of each of these position papers, with dates and places where the issues were spoken to (Council Meetings, House of Delegates Meetings, etc.) for use by those interested in reviewing them.

Lastly, I would be remiss if I did not state generally how pleased and honored I am to work with the other Medical Association officers, committee chairmen, and members, as well as our excellent staff in the headquarters office. As it has been my sincere and deep pleasure to serve you in the past, so again I recommit myself to your service in behalf of us all during this coming year. Thank you.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee reviewed with great interest the report of the President-Elect. Our President-Elect is to be commended for the thoroughness and the thoughtfulness of his fine report. We wish to specifically commend him for his comments on the identification of physicians and the medical profession as spokesmen for patients, the true consumers of medical services. In considering this report, your Reference Committee concluded that the paragraph beginning with the words "On reflecting on this editorial, I recalled a portion of an article that I wrote for the JMAG four years ago . . ." should be deleted in its entirety. Your Committee felt that contrary to the comments in this paragraph, the giving of practice time by physicians in the active practice of medicine to making decisions in their medical organizations is a small price to pay for their continued control over the direction and planning of the medical care delivery system.

In reviewing the recommendations made by the President-Elect, your Reference Committee concluded that it would be more appropriate for Reference Committee F to make the recommendations on the first recommendation and, therefore, defers action on Recommendation 1.

Recommendation 2, on the size of the MAG House of Delegates, your Reference Committee felt that consideration of this most important topic would be more appropriate to the MAG Committee on Organization and Structure and, therefore, we recommend that it be referred to this Committee for extended study and recommendation back to the annual meeting of this House of Delegates in 1975.

On Recommendation 3, your Reference Committee concurs that there is at present no system of checks and balances in the Association for expenditure of funds by the Council. If this House concurs that such a system is needed, your Reference Committee would recommend that the following statement by added at the conclusion of the paragraph *"Therefore, the Committee on Constitution and Bylaws is instructed to prepare language to amend the Constitution and Bylaws in the following manner:*

"1. To set maximum limit for unbudgeted expenditures by Council,

"2. To reconstitute the MAG Finance Committee as a Committee of the House of Delegates rather than a Committee of the Council,

"3. To authorize the Finance Committee of the House of Delegates to consider and approve expenditures recommended by Council beyond the limitation set for Council."

Your Reference Committee considers that the establishment of this new Finance Committee of the House of Delegates would create a more appropriate system of checks and balances in the expenditure of MAG funds. It should be noted that these recommendations, if adopted, would be referred to the Constitution and Bylaws Committee for report back to this House of Delegates for consideration at its next meeting. This would give sufficient time for careful consideration of this recommendation and give adequate exposure of this concept to the membership for their consideration.

On Recommendation 4, your Reference Committee wishes to highly commend and compliment the President-Elect for taking upon himself the responsibility for developing a series of policy statements for the Medical Association of Georgia. It is the recommendation of your Committee that the recommendation be amended by adding the following sentence at the conclusion of the paragraph *"The finished document shall be presented to Council for its consideration and any questions, or issues, that are challenged shall be referred to the House of Delegates for its consideration."*

HOUSE OF DELEGATES ACTION—Adopted the report of the President-Elect as amended by the Reference Committee.

COMMITTEE ON EDUCATION

Nicholas Davies, M.D.

Medical education, including the teaching of medical students, the postgraduate training of medical school graduates, the continuing education of practicing physicians and the teaching of allied health personnel, has changed dramatically during the past few years. It promises to change even more dramatically during the next decade. The Committee on Education believes that the Medical Association of Georgia has an obligation to its members and to the citizens of Georgia to assume some responsibility for these changes.

The MAG has the opportunity to participate in the formation of new programs and to help guide changes in old programs. Specifically, the Committee on Education believes that the MAG, as the leader of organized medicine in Georgia, must assume primary responsibility for the continuing medical education of practicing physicians in Georgia, whether or not they are members of the organization. Secondly, the Committee believes that the MAG must assume the responsibility for promoting the education of the citizens of Georgia about health related subjects. Medical school

and postgraduate medical education are not the direct responsibility of organized medicine, but they should be of concern because the products of these systems will become practitioners and members of the MAG. Lastly, the role of organized medicine in the training of allied health personnel has not yet been clearly defined.

If the MAG accepts a leadership role in medical education in Georgia, the Committee on Education believes that the MAG should acknowledge this by revising its table of organization and putting education on an equal level with legislation, public relations, member services (insurance programs, publications, etc.) and government relations (GRMP, CHAMPUS, EMCRO, etc.). Professional competence, in a large part a reflection of education, ranks closely behind physician availability and health care costs as a major concern of the general public. By increasing its support for education, the MAG would strengthen its position of promoting quality medical care for the people of Georgia, a positive, clearly delineated position.

In the fall of 1975, the MAG will sponsor a scientific session that will be organized by the Interspecialty Council aided by the Committee on Education. The current Task Force on Continuing Medical Education is becoming increasingly active, especially its Subcommittee on Accreditation. The Committee on Education foresees greater activity in the continuing medical education field should PSRO or similar legislation be implemented. In view of these changes, the Committee on Education believes that a staff position that might be called Education Coordinator should be established within the professional structure of the MAG to assist the various groups concerned with educational matters. This position has already been established in many state medical societies and has proved extremely useful. This recommendation has been made in previous reports to this House of Delegates.

The Committee on Education, which was restructured several years ago, served its intended function. However, several of the Task Forces have been inactive and are no longer needed. The Committee on Education believes that it could function more efficiently with four subcommittees. These would be (1) Subcommittee on Medical Schools, (2) Subcommittee on Continuing Medical Education, (3) Subcommittee on Nursing, (4) Subcommittee on Public Education.

1. The Subcommittee on Medical Schools, currently chaired by Victor A. Moore, has been in effect since 1965. It has held a biannual or annual meeting at which representatives of the two state medical schools and the MAG have discussed mutual problems. The meetings have been beneficial to all. The meeting that was held in Augusta in March of this year was extremely productive. From it, much of the material contained in this report was generated.

2. The Subcommittee on Continuing Medical Education, currently chaired by Richard Thompson, has been especially active in the field of accreditation. The accreditation function was approved by the AMA in 1973. Since that time, under the leadership of LaMar McGinnis, three educational programs have been surveyed and approved. These are the CME programs of Piedmont Hospital in Atlanta, Georgia; the Atlanta Graduate Medical Assembly; and the program of the Medical Center, Columbus, Georgia. There are currently three requests for surveys of other organizations within the state. Additionally, a number of MAG members are serving on CME Survey Teams for the AMA.

3. The Subcommittee on Nursing, chaired by John Page Wilson, has been in existence since 1972. It has served a very useful liaison function with the nursing profession. Because of its continued activity, it will be kept intact.

4. A Subcommittee on Public Education is proposed. Its function would be to promote public education in all matters regarding health. The need for this subcommittee was stressed at the March meeting of the Medical School Subcommittee. There it was agreed that an educated public which had some medical sophistication might be the greatest time-saver the medical profession could find. At the same time it was pointed out that no single group in Georgia was responsible for promoting health education in the citizens of the state. There are many problems that need to be resolved, a few of which might be as follows: (a) Promoting better health education among school teachers, i.e., teaching the teachers what to teach; (b) Assisting health agencies in their educational activities which are so often uncoordinated and wasteful of needed funds; (c) Promotion of health education on radio and television, as well as other news media. The possibilities are almost unlimited, especially if combined with other groups such as Public Relations, the Committee on Quackery, etc.

Should the reorganization of the Committee on Education be approved, the Committee would meet approximately one month after the annual session and charge each of these subcommittees. At that time, specific goals would be set and "critical paths" would be established so that the accomplishments could be measured and some idea of cost accounting could be made.

The Committee on Education and the Task Force on Medical Schools at their March meetings in Augusta reached one major conclusion: there is a dearth of hard data on health care manpower in the state. Without this information, neither the problems nor their solutions can be adequately studied. One of the discussion groups made this recommendation: "The Medical Association of Georgia should assume the responsibility for an indepth study in our state by creating a Task Force to inventory manpower, health care, and resources by means of a survey similar to the Virginia study on physician manpower availability." An example of our need in Georgia is that of the Georgia Council for Family Practice Education which is trying to find out how many family physicians are actually needed in the state so that they might establish the proper number of family practice residency positions. Another example concerns the number of foreign medical graduates who are currently practicing in Georgia. How many are there, where are they practicing, and what are their special educational needs? These are only two of the many questions that need to be answered before sound planning by any group can be done.

The discussion groups at the meeting of the Task Force on Medical Schools reached a number of conclusions. The major ones are listed below, not necessarily in any order of priority or importance.

1. The major problem in continuing education for physicians was that of motivation. If each physician could be properly motivated to continue his education, there would be no problem. Those physicians who do

not participate in CME generally fall into one of two groups: (a) Absolute disinterest; (b) Too conscientious to leave their patients with another physician or without any temporary medical care.

2. Continuing Medical Education is best carried out on a day-to-day basis at the community hospital level.

3. The requirement to participate in a specified number of hours of continuing education, obtaining the so-called "brownie points," does not seem to be a very good way to ensure that a physician continues his education; but, there is evidence that this method has indeed stimulated further interests in continuing education and, from that standpoint, has been a definite positive factor.

4. Motivation for increasing one's education might come about by creation of a local or regional program of Directors of Medical Education. It was suggested that these directors might be located in each PSRO sub-area, should this legislation not be repealed. These physicians would identify local needs through audit and utilization review, contact medical schools with specific requests and help set up continuing education programs. They might serve as Directors of Medical Education for a number of small hospitals, each of which could not afford to support a professional director of education.

5. The problem of patient education was discussed at great length by several groups. It was the consensus that if patients were properly educated about common medical problems, the physicians of the state would be free to do other things with their valuable time. This might also lessen the number of malpractice suits, decrease the cost of medical care and have other salutary effects.

6. Relicensure and recertification were discussed and it was the consensus that these problems will present themselves in time, but as yet do not need to be strongly considered in Georgia. It was felt that the physicians of the state need to know what is going on in other states and that perhaps the MAG should have an Ad Hoc Committee to keep an eye on changes that might affect us in the future.

7. One group felt that the MAG should assist communities in locating physicians by counseling the city leaders on methods of presenting their community in its best light. (A similar report has come from the Ad Hoc Committee on Access to Health Care.) The MAG should serve as consultants with regard to medical facilities, establishing "partnerships for health" with nurses, pharmacists, hospitals and physicians. MAG should encourage preceptorship in community medicine as is being done in Texas and other states. The MAG needs to come out with a positive statement on its position on these matters and take an active role in developing them.

8. The responsibility of medical care, including the quantity of physicians, the quality of the care that they give, and to a certain extent the cost of this care, belongs to the local medical societies. The committee believed that the Medical Association of Georgia should assist these local societies in understanding and carrying out this responsibility.

9. There is a great need for research and development in the health care area. As noted above, basic hard data is needed for planning. The use of the EMCRO machinery was discussed at some length by one of the discussion groups.

10. It was the consensus that the meeting of the Task Force on Medical Schools was quite informative and that it should be continued on a biannual basis. The next meeting is tentatively scheduled for Macon, in 1976.

RECOMMENDATIONS

1. That the Medical Association accept the primary responsibility for the continuing education of the physicians within the state and the primary responsibility for the general health education of the people of Georgia. And further that the Medical Association of Georgia continue to be concerned, although not primarily responsible, for education within the medical schools, for postgraduate training programs, for nursing schools and for schools of allied health personnel within the state.

2. That the Medical Association of Georgia endorse the concept of a full-time educational coordinator on the staff whose job it should be to coordinate all educational activities and scientific sessions within the organization.

3. That the Medical Association of Georgia endorse the concept that local medical societies should take leadership roles in being responsible for the health care of the communities in which they are located and that the Association encourage local medical societies by giving them advice along these lines.

4. That the Committee on Education be restructured and that henceforth contain subcommittees on Continuing Medical Education, Nursing Medical Schools and Public Education.

5. That the MAG support a comprehensive study of the physicians practicing in the state of Georgia. This would be directed toward the location of their practice, the extent of their practice, their area of coverage, and it would determine as objectively as possible the presence of a shortage or maldistribution of physicians within the state. It would be funded by an acceptable source and perhaps other information might be obtained during the study which could be useful to health care planners.

6. That the MAG appoint an Ad Hoc Committee to Study Relicensure and Recertification in the U. S. and its application for the State of Georgia in the future.

7. That the MAG be cognizant of the concept of regional directors of medical education.

8. That the Medical Association of Georgia take an aggressive role, once reliable data is available, to assist communities in obtaining physicians.

9. That the MAG investigate the need for a research and development arm within the Association, probably separate from other divisions, so that it could present its findings as objectively as possible.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of Recommendation 1 as amended so that it would now read, "That the Medical Association of Georgia accept the primary responsibility for the continuing education of the physicians within the state and *for providing continuing input into all aspects of* the general health education of the people of Georgia. And further, that the Medical Association of Georgia continue to be concerned, although not primarily re-

sponsible, for education within the medical schools for postgraduate training programs for nursing schools and for schools of allied health personnel within the state."

Your Reference Committee heartily concurs with Recommendation 2. The Committee recognizes the importance of continuing medical education for physicians and perceives that this function at the staff level should receive adequate recognition. In consideration of this recommendation, the Reference Committee wishes to point out that it will cost approximately $30,000 per year to hire staff, pay for travel expenses, office equipment and supplies for the performance of this activity. Your Reference Committee was advised that it is possible that a portion of these funds may be obtainable from the Regional Medical Program for at least the first year. Your Reference Committee wishes to further recommend that the following be added at the conclusion of the paragraph: *"This staff activity should be pursued on a two year basis, with a report to be provided to the 1976 annual meeting of the House of Delegates with a full statement on the activities that have been accomplished, including a report on the scientific session, held in October, 1975."*

Your Reference Committee heartily endorses and recommends approval of Recommendations 3 and 4 and wishes to especially commend the Chairman of the Education Committee for restructuring his Committee to include a Subcommittee on Public Education.

On Recommendation 5, your Reference Committee recommends approval with the following comments:

In order to achieve the type of study suggested, the Committee suggests that the Education Committee seek out acceptable financial support from agencies, such as the Georgia Regional Medical Program and the Comprehensive Health Planning Agency for the State of Georgia. Further, your Reference Committee wishes to encourage the Education Committee to continue and to expand its contacts with the medical schools to advise them of our support for the training of primary medical care physicians.

On Recommendation 6, your Reference Committee considers this question worthy of further study and deserving of MAG's consideration. We, therefore, recommend approval with amendment to read as follows:

"That the *President of MAG refer to an appropriate* Committee the study of relicensure and recertification in the U. S. and its application for the State of Georgia in the future *with a report to be made to the annual meeting of the House of Delegates in 1975."*

Your Reference Committee wishes to bring to the attention of the Committee which receives this charge that mechanisms of evaluation for relicensure and recertification should recognize the limited value of written examinations and the desirability of considering more practical methods of evaluation.

Your Reference Committee recommends approval of Recommendations 7 and 8.

On Recommendation 9, your Reference Committee recommends approval with the addition of the following at the conclusion of the paragraph: *"This shall be referred to the MAG Executive Committee for consideration with a report on its findings back to the annual meeting of the MAG House of Delegates in 1975."*

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Education as amended by the Reference Committee.

GEORGIA MEDICAL CARE FOUNDATION

F. W. Dowda, M.D.

This past year has been a very significant one in the life of the Georgia Medical Care Foundation. Membership has increased, and changes have taken place, and it is my pleasure to be able to report these things to you at this session of the House of Delegates.

Perhaps most important is the development and implementation of the Specialty Panel method of peer review. As directed at the last annual business meeting of the House of Delegates, the Board of Directors of the Foundation has divested itself of the responsibility to act as the appellate arm of the peer review system. Instead, this function has been given over to a group of 16 (soon to be 19) specialty panels composed of from six to 12 physicians in each of the medical specialties represented. These specialty panel members are, for the most part, board certified in their specialty, and nominated by their state-wide specialty societies to serve on these panels. The panels meet approximately every other month at the offices of the Foundation, and are now functioning regularly.

Also of general note is the Foundation's move into more permanent quarters. After several years of separation and inconvenience, all Foundation functions are now located at 1100 Spring Street, Suite 450, in Atlanta. A WATS line has been installed for use by the physicians of Georgia, and our staff is happy to discuss whatever problems you may be having that concern the Foundation.

I would now like to turn my attention to more specific areas.

MEDICAID PROGRAM

Both the hospital and physician aspects of the Medicaid Program are operating at approximately the same volume as last year, although much more smoothly and quickly thanks to the implementation of the Specialty Panel review process.

The Nursing Home Program mentioned to you last year at this time is now nearly a year old and functioning extremely well. By the time you read these remarks, well over 300 of the 350 nursing homes will have been visited by the Foundation teams, and each of their respective Medicaid patients seen, as called for in the state contract. A telephone-based pre-admission certification of level of care has been in operation since February, and is also functioning well.

In addition, a regular 60-day recertification of level of care is in operation.

CURRENT CONTRACTS

Contracts or sub-contracts for the delivery of peer review services are currently in effect between the Foundation and the following agencies or organizations: Georgia Department of Human Resources, Atlanta Blue Shield, Metropolitan Insurance Company, and CHAMPUS. In addition, monthly meetings with

the representatives of the Georgia Health Insurance Council continue, with a much greater level of understanding apparent at each successive meeting.

CONCURRENT HOSPITAL REVIEW PROGRAM (CHEC)

As this report is being written, efforts are afoot to begin the implementation of the Foundation's concurrent hospital review program throughout the State of Georgia for Medicaid and Medicare patients. The benefits of a program of this type are several, including the elimination of retroactive denials currently suffered by hospitals, the rctention of the responsibility for review of medical services with the practicing physician and within the hospital medical staff, and the development of a truly viable, medically-run alternative to PSROs. It is expected that once this program is established for Medicaid and Medicare patients, it may well be expanded to include the review of patients hospitalized under private insurance plans.

NEW BOARD OF DIRECTORS

A new Board of Directors composed of 10 directors, 10 alternate directors, and three ex-officio directors of the Foundation was elected at the March Meeting of Council in Macon by the administrative members of the Foundation and new officers have been elected by this Board.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends that this report be filed for information. In reviewing the contents of this report, the Reference Committee wishes to commend the scope of activities and the initiative shown by the Georgia Medical Care Foundation's Board of Directors.

HOUSE OF DELEGATES ACTION—Adopted the report of the Reference Committee which recommends that the report of the Georgia Medical Care Foundation by filed for information.

COMMITTEE ON EMCRO

Ollie O. McGahee, Jr., M.D.

IMAGE, the hospital discharge abstract system of the Medical Association of Georgia, is currently functioning in 19 hospitals in Georgia. These hospitals range in size from approximately 45 beds to 350 beds and are located in various areas of the state. Reports are being returned to hospitals and medical staffs are utilizing them in the review of care provided in their own hospital. Six of these 19 hospitals are in the operational phase, paying $.75 per discharge. The remaining 13 become operational July 1. IMAGE is operated in a sound financial manner, maintaining its $.75 charge, and incurring no obligations beyond its resources.

IMAGE was designed to help meet audit and statistical requirements of the Joint Commission on Accreditation of Hospitals. In order to assure that such standards are met, IMAGE staff members have met with JCAH staff on several occasions to confer concerning common interests and goals. One topic discussed was how the MAG data system provides an aid to medical audit for hospitals, with documentation, action, and follow-up accomplished by physicians in the hospital. Additional meetings with JCAH staff will occur during the next year.

Hospital personnel from the medical record department of participating hospitals are trained in a one-day abstracting-coding seminar. At least one such session is held each month. Additional consultations are provided to hospitals to identify laboratory tests and suggest procedures to facilitate the abstracting process. A manual, including item-by-item instructions, has been developed for the abstractors. Included are definitions of abstract items, examples of correct abstract entries and explicit instructions on categorization of laboratory and drug information. After a period of two to three months, time studies indicate, on the average, the abstractor will abstract a medical record in 15 minutes. For a prompt response to questions or problems encountered by hospital medical record personnel, an incoming WATS line is available.

In order to review care provided, accuracy of data is essential to physicians. During the initial phase of participation, diagnostic and surgical codes are written in the narrative and coded by the abstractors until an acceptable level of accuracy is achieved. The abstracts are screened through approximately 380 edit checks to assess the completeness and validity of the coded information. Those abstracts not meeting the edit screens are identified and corrected before processing.

One of the most important features of the hospital discharge abstract system is the availability of a competent staff to assist hospital medical staffs, medical record personnel, and administrators. IMAGE personnel are always available to discuss any aspect of the hospital system. An IMAGE health record analyst goes to a participating hospital to provide instruction in the analysis and effective use of reports. Currently, one-day courses are being offered to train interested personnel, including hospital health record analysts and administrators. Such training enables the hospital health record analyst to provide invaluable assistance to the committees who review patient care. The course covers discussion of medical care evaluation, criteria development, how to complete a medical audit study, and use of IMAGE reports. Such classes are expected to expand to include additional topics at a later date.

As a physician-directed abstract system, IMAGE continues to be marketed primarily through medical staffs. In order to describe the use of the data system in quality assurance efforts, a one-day seminar for hospital chiefs of staff, chairmen of medical audit and utilization review committees, administrators, and medical record administrators will be conducted throughout the state during the spring and summer. The advantage of a regional data system with flexibility to meet the needs of that region will be emphasized.

This committee feels strongly that confidentiality of medical information in computerized data systems is best safeguarded when such data collection systems are operated by organized medicine—as IMAGE is operated by the Medical Association of Georgia. IMAGE's confidentiality procedures are such that only the hospital's medical record department can identify the patient or physician from their reports. Users of other data systems should determine who has access to their codes. Fiscal intermediaries of Federal Health Programs (as Medicare) or insurance carriers who have access to such data and their codes have all that is necessary to generate physician profiles.

Small Hospitals Project

The Georgia Regional Medical Program has funded a proposal submitted by the Medical Association of Georgia to assist in the development and implementation of a program whereby the medical staffs of small hospitals (i.e., of 100 beds or less) may evaluate the quality of medical care in their facility. Because of the small number of beds, small medical staffs, and lack of resources, it is believed that small hospitals will particularly benefit from special assistance in developing objective methods of review. The specific objectives of the project are:

1. To assist small hospitals in meeting JCAH accreditation standards with respect to medical audit and utilization review.
2. To assist small hospitals in the improvement of the medical record to make it auditable.
3. To assist small hospitals in the development of a workable medical audit system.
4. To assist small hospitals in the development of a plan for corrective education based on identified needs.

MAG teams will operate in three to five small hospitals in North Georgia, Central Georgia, and South Georgia areas. Each team will consist of a physician, a nurse health record analyst, and an MAG medical record administrator. Physicians serving on the teams are: Luther G. Fortson, M.D., Marietta; Ollie O. McGahee, M.D., Jesup; C. Daniel Cabaniss, M.D., Columbus; M. Charles Adair and A. D. Duggan, M.D., Washington.

The teams will utilize IMAGE in assisting small hospitals in the development of a medical care evaluation program. The criteria developed by the state specialty panels will be utilized as flexible guidelines which the medical staffs of small hospitals may modify. Participating hospitals would provide an abstractor trained by IMAGE medical record staff. The team physician and health record analyst would assist the medical staffs in the analysis and use of data. Continuing education would be planned.

The project has been funded for a six-month period. Plans are to expand the project, with more teams and hospitals for an additional year.

Criteria Development

Currently, 130 criteria have been developed by state specialty panels. These have been computerized to be utilized as "screens" to assist medical staffs in their review of hospital care. Medical staffs of participating hospitals have begun to review criteria to submit recommendations for criteria modification to the chairman of the state specialty panels.

Panels have begun meeting for the purpose of revising criteria, utilizing data returned during the field test program. Such modifications include: better definition of the diagnosis, specifying additional elements "critical" to high quality care, and specifying procedures or management which should be identified for additional review. Panel members are suggesting additional categories they feel would assist in review of quality of care.

In order to continue and expand the criteria development activity, a letter of intent has been submitted to the Georgia Regional Medical Program to enable IMAGE staff to meet with panels to develop additional criteria, to modify existing criteria, and to expand criteria to include elements of the physical exam as well as pertinent items of medical history. Such a project would allow panels to examine the feasibility of obtaining lab values and utilizing such information in specifying criteria.

Another area of interest in criteria development is that of "outcomes" or results of care. Currently, staff members are developing a means of assessing the feasibility of including outcomes into the IMAGE medical care assessment procedures. Funding has been requested for support of this activity. The initial activities undertaken will involve the revision of a limited number of existing criteria by the specialty panels, to include in-patient outcome parameters. Outcome parameters specified would be limited to patient data available from the medical record at discharge, but would reference outcomes measured during the course of hospitalization, as well as patient status at discharge. Data to be collected may include laboratory values, pathology results, findings on the history and physical, complications arising during hospitalization, and other morbidity measures that would support a given diagnosis or indicate health status during hospitalization, or at discharge. After training hospital medical record personnel, outcome data would be obtained for a limited number of diagnosis from hospitals participating in IMAGE. Following analysis of the data, reports would be available to specialty panels and to the hospitals participating in the feasibility study. In addition to the collection of in-patient outcome data, post-hospitalization data will be obtained in cooperation with the participating hospitals and physicians for a sample of the patients. This data will be used to assess the relationship between compliance with IMAGE process criteria and outcomes of care, and to assess the relationship between in-patient outcomes and post-hospitalization outcomes.

Continuing Education

Identification of continuing education needs is an integral element of a medical care evaluation system. The Georgia Regional Medical Program has funded the Medical Association for a "Quality Assurance and Continuing Education Effort." The project has supported the IMAGE criteria development activity. These guidelines are those by which patient care as reported on an IMAGE abstract is compared. Those patients not meeting the criteria are reviewed by the hospital medical staffs to determine whether variation from the criteria indicates a need for continuing education. Staff are currently in the process of structuring programs based on these identified needs.

Another continuing education related activity for which the Medical Association has sought support is one relating to cancer education. There are four tasks to be accomplished during the funding period. The first is to document continuing education activities occurring during the preceding year, to include contacting appropriate organizations and individuals throughout the state. These activities are then evaluated to determine effectiveness and appropriateness as related to patient care. Results of this evaluation will be utilized to plan continuing cancer education programs based on identified needs. These programs would be planned in cooperation with existing structures such as MAG's Annual Scientific Session, and the Georgia Chapter of the

American Cancer Society programs. The final task is one of evaluation which would utilize IMAGE, and the tumor registry, as well as other methods determined effective during the initial evaluation phase.

Nursing Home Program

The Committee on Geriatric Medicine (Joseph S. Wilson, M.D., chairman) will soon meet to review the progress of the nursing home component. The major developments within this component are described below.

Funding has been requested to develop, implement and evaluate a common method for medical record keeping in nursing homes in the State of Georgia. A data validation study was undertaken by the nursing home program staff to verify the validity of the data currently being collected from nursing home medical records. The results of this study indicated that attention should be given to the quality and consistency of medical record keeping procedures in Georgia nursing homes. One important factor is that trained medical record personnel are not generally employed by nursing homes. With this in mind, the grant on medical records in nursing homes proposes to accomplish the following: 1) to establish baseline data on existing medical record keeping practices in nursing homes in Georgia; 2) to develop a common medical record keeping system; 3) to develop a curriculum for training sessions in this system; 4) to implement this common medical record keeping system statewide through local and regional seminars; and 5) to evaluate the effectiveness of the system.

Funding has also been requested to modify the existing nursing home system to meet the needs of on-site medical review by aggregating data at the level of the nursing home itself (as distinguished from reporting data at the level of the individual patient or on a statewide basis). Reports will be developed indicating the degree of compliance with criteria for evaluation of both appropriateness of skill level and quality of care. The effect on the review process will be evaluated in terms of allocation of time, use of personnel and other resources, as well as on the process and results of review.

In the area of continuing education, the nursing home program staff will organize a seminar on "The Role of the Medical Director in Long-Term Care." This seminar will be co-sponsored with the Georgia Nursing Home Association and will be held on October 18-19, 1974 in Atlanta.

Other Health Statistics Efforts

In accordance with the directions of the House of Delegates in December, our health statistics activities are being expanded, and are expected to include the operation of a statewide cancer registry beginning in July. Georgia has been without a registry since June of last year.

A responsibility of our staff that is of major practical significance to physicians and other providers of health care (hospitals, nursing homes, etc.) is insuring that unnecessary requests for health data duplicating already existing information requirements by state and other agencies are minimized. Federal, state, and local requirements are being catalogued and efforts made to reduce the overlap and duplication already present. We are encouraging such agencies (as well as other organizations) to utilize existing data bases rather than develop new special-purpose data collection systems as additional data needs are identified.

EMCRO FINANCIAL EXPENDITURES
(Fiscal Year Ending 5/31/74)

		Actual (Thru April 30, 1974)	*Budget*
1. Personnel			
Salaries	$65,460.31		
Fringe Benefits	12,787.72		
		$ 78,248.03	$ 96,541.00
2. Consultants			
Pharmacy	$ 3,310.00		
Computer	715.42		
Criteria Development	448.00		
Medical Records Reality Orientation Seminar	870.08		
	1,031.60		
		$ 6,375.10	$ 20,000.00
3. Equipment			
Office Equipment	$ 1,935.40		
Office Furniture	1,779.09		
		$ 3,714.49	$ 7,250.00
4. Supplies			
Office	$ 9,499.67		
Duplicating	7,580.30		
Visual Aid	192.10		
		$ 17,272.07*	$ 16,000.00
5. Travel			
In-State			
Training	$ 3,770.65		
Conferences	3,464.76		
Criteria Development	2,241.91		
Administrative	962.17		
Out-State			
Training	$ 3,600.21		
Conferences	3,349.34		
Administrative	3,945.49		
		$ 21,334.53	$ 28,000.00
6. Other:			
E.D.P. Services		$ 46,020.30	$ 85,734.00
Postage		$ 1,109.41	$ 2,500.00
Publications		$ 2,110.79	$ 3,500.00
Printing			
Hospital Program	$ 4,932.18		
Nursing Home Program	803.64		
Criteria Development	1,273.42		
Visual Aids, Forms, etc.	181.27		
		$ 7,190.51*	$ 6,500.00
Registration Fees		$ 4,361.00	$ 4,500.00
Telephone		$ 7,968.31	$ 9,000.00
Equipment Lease		$ 624.32	$ 4,800.00
		$196,328.95	$284,325.00
Indirect Cost		11,315.25	14,747.00
Totals		$207,644.20	$299,072.00

* Authorization for a modification to this budget category is being processed.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends the filing of this report for information and further wishes to commend the Committee and especially the Chairman for his official and personal efforts to test in action the concepts outlined in this report. Reference Committee suggests that a recommendation be added to this report at the conclusion of the section entitled, *"Other Health Statistics Efforts." "The desirability*



Making use of an opportunity to tell MAG's story to the public, Dr. Bohler explains to JWCL-TV news director Douglas Weathers why not every community can support a physician.

of a continuing statewide tumor registry is recognized by this House of Delegates. Because of the uncertainty of federal funding for EMCRO, the operation of a tumor registry should not be unalterably related to the EMCRO activity. In order to obtain a satisfactory plan for obtaining long term funding for a statewide tumor registry, the development of a proposal to include a budget is referred to the MAG Committee on Cancer with the expectation of a report to be made back to the House of Delegates at its annual meeting in 1975. It is recognized that it may be necessary to utilize MAG's funds for the operation of a statewide tumor registry."

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on EMCRO as amended by the Reference Committee.

IMMEDIATE PAST PRESIDENT

F. W. Dowda, M.D.

RECOMMENDATIONS

I have only two recommendations to make at this time:

1. By the time this report reaches your hand, Georgia should have been designated a single statewide PSRO. In light of this cooperative governmental attitude, I feel that MAG should reverse its position and seek amendments to the objectional features of the PSRO Law and cease to seek repeal.

2. In light of the growing complexity of medical problems and increasing number of subsidiary corporations of the Medical Association of Georgia, I would like for the House of Delegates to again consider the creation of the position of the Medical Director of the Medical Association of Georgia.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends disapproval of this report in its entirety. Your Reference Committee recommends this action on recommendation (1) since the Immediate Past President, before the Reference Committee hearings, withdrew this recommendation and because it is inconsistent with the Committee's conclusions on PSRO stated later in this report. On Recommendation 2, it is the opinion of your Reference Committee that obtaining a salaried M.D. medical director is not in the best interest of the Medical Association of Georgia or the patients of Georgia in that both would be better served by the continuance of leadership of MAG by practicing physicians.

HOUSE OF DELEGATES ACTION—Adopted the report of the Reference Committee and thus disapproved the report of the Immediate Past President.

PSRO Preamble

It has been pointed out and is recognized by the Committee that the primary underlying evils in the extant PSRO legislation reside in the substructure of the Social Security Act itself, governing Medicare and Medicaid, and it is understood that the PSRO concept in part represents an outgrowth of efforts to institute physician review rather than lay review of medical practice. It is also recognized that dissolution of the PSRO concept would still leave unmodified the authority of the Department of HEW to regulate much of medical practice. It is further perceived by the Committee that the concept of peer review is eminently to be desired over review and regulation by unprofessional administrative and hence inadequately trained personnel.

Nonetheless, the Committee views existing PSRO legislation as providing onerous roadblocks to the effective prosecution of quality medical care, holding no hope of reducing medical costs but rather escalating them; as constituting a substantive threat to the medical welfare of the consumer, the patient; and, most of all, as offering insuperable interference with the concept that the delicate process of physician decision making, difficult as it often is, should go forward unimpeded by arbitrary legislative and fiscal considerations imposed from without.

This position has already been endorsed and impressively activated by the MAG and great progress has been made.

RESOLUTION 74-5 AMEND PSRO LAW

James H. Sullivan, M.D., in behalf of the Muscogee County Medical Society

WHEREAS, the Medical Association of Georgia House of Delegates should pass a resolution to repeal the PSRO law, and should strive to achieve this goal; and

WHEREAS, the PSRO law, if not repealed, would create severe problems to patients and physicians; and

WHEREAS, our efforts should be directed not only at repeal but also at proposing amendments to eliminate the most onerous portions of the law; and

WHEREAS, the American Medical Association has proposed certain amendments to the PSRO law; and

WHEREAS, we should seek a common sense approach by advocating the enactment of meaningful

amendments designed to make the law less obnoxious at the same time we work for repeal.

NOW THEREFORE BE IT RESOLVED that the MAG endorse the efforts of AMA to amend the PSRO law; and be it further

RESOLVED that the MAG submit a resolution to the AMA House of Delegates meeting in Chicago in June supporting the AMA's amendments to the PSRO law; and be it further

RESOLVED that this resolution also be considered by the House of Delegates as a minority report of the Committee on PSRO.

REFERENCE COMMITTEE RECOMMENDATION —It is, therefore, the unanimous opinion of Reference Committee C that all efforts should be directed toward unqualified repeal of PSRO. No present efforts should be expended in the lesser task of seeking amendment (therefore recommending disapproval of Resolution 74-5).

HOUSE OF DELEGATES ACTION—Adopted the report of the Reference Committee thus disapproving Resolution 74-5.

Efforts to obtain planning contracts while seeking repeal are viewed as inconsistent, diversionary, and unworthy of a group with such solidarity of purpose.

In order to assure that there be a clear understanding of the position of the Medical Association of Georgia on the issue of PSRO, your Reference Committee wishes to report on the various items concerning PSRO, individually.

COMMITTEE ON PSRO

Charles D. Hollis, Jr., M.D., Chairman

At the called meeting of the MAG House of Delegates in December 1973, your committee reported at some length on facts and fears related to the PSRO Law as it saw them at that time.

The Executive Committee of the MAG, in accord with the instructions from the House of Delegates, has been conducting a vigorous campaign to attempt to solicit support for repeal of PSRO. Efforts have been made to educate the profession, the public, and the legislators regarding the potentially undesirable effects of the PSRO program.

The study committee on PSRO, in response to other directions from the House of Delegates, has been: (1) continuing to study the progress being made toward implementation in other states, and in development of guidelines by the HEW; (2) identifying sections of the present law which should be amended; and (3) working toward preparation of an alternate plan.

There has not been uniform agreement within the committee as to the likelihood of success in the repeal campaign, nor as to the advisability of continuing to prepare an alternate plan for possible use at a later date. Nonetheless, the committee has continued to function cooperatively in all areas.

In March 1974, after many physicians in Georgia protested the division of the state into three areas, the HEW reconsidered and declared Georgia a single PSRO area. This was due in large part to the influence of Senator Herman Talmadge and in consideration of the fact that the Georgia Medical Care Foundation has been functioning quite well in review activities.

As the study of the issue has continued, information has become available which was not previously known. Certain facts stand out clearly which require the concerned physician to change his perspective in analyzing the impact of the PSRO system. A listing of the events leading up to PSRO, in chronological order, is essential in the full understanding of its significance.

1. In the Social Security Act establishing Medicare and Medicaid, the Secretary of HEW was authorized to gain access to medical records, to set up a review mechanism with statewide review teams, to appoint members to the review teams, "with appropriate consultation," the members to be composed of physicians, other health care practitioners, and representatives of the public. The HEW Secretary was to identify, in ways which he himself established, those who abused the system. He could then suspend or disqualify the offender from payment under programs covered by the Social Security Act. Public disclosure was to be made of the names of physicians decided to be rendering inferior or inappropriate medical care. By 1970, he had not chosen to implement this authority.

2. In 1970, the House Ways and Means Committee voted to recommend that the Secretary of HEW exercise the power granted to him under the law, and organize "Program Review Teams" in an effort to slow the escalation of the costs of the Medicare-Medicaid program.

3. The AMA, almost by accident while it was testifying on the Medicredit Bill, learned of this recommendation that HEW set up Program Review Teams and quickly developed an alternate plan, incorporating peer review mechanisms. They solicited and obtained support from Rep. Wilbur Mills and temporarily halted the progress of the development of these HEW review teams. The peer review concept, called "PRO," or Peer Review Organization, was added to the existing Medicredit Bill.

4. Sen. Wallace Bennett was asked by the AMA to sponsor the PRO concept, but instead found that he was not in agreement with the proposals that the peer review mechanism be controlled by the state medical societies and that only physician services should be reviewed. Rather, he felt that the basic authority for review should rest with hospital medical staffs, should not be controlled by state medical societies and that physicians should be responsible for institutional as well as physician services. He then offered a substitute bill known as the Professional Standards Review Organization Act of 1970, incorporating his ideas including the power to require financial reimbursement by a physician, when recommended by his peers on a PSRO committee, in cases of "flagrant abuse."

5. PSRO superceded the authority vested in the HEW Secretary to appoint program review teams and specified the review processes would be performed only by practicing physicians, M.D.s and D.O.s with the basic unit of review located in the local hospitals. Criteria, standards and norms were to be established individually by each hospital medical staff, also composed only of practicing physicians.

The controversy, then, actually revolves about the question, not of *whether federally mandated review will be performed, but whether it will be performed by*

a practicing physician's peers in his local hospital, or by appointees of the Secretary of HEW.

The PSRO law specifically states that participation in its activities is voluntary. Physicians can, in effect, "repeal" the PSRO system by refusing to participate in PSRO activities. In this case, the authority for organizing, directing and controlling review procedures would revert back to HEW. Congressional repeal of the PSRO would accomplish the same thing, again reverting authority back to the HEW Secretary in the same way, under authority vested in him by the original Medicare-Medicaid laws. Because of the voluntary nature of the program, physicians can "repeal" PSRO in two ways: (1) By refusing to participate; (2) By obtaining congressional repeal of the act. In each case, the same PSRO review-type processes would be performed in the same way under direction of the Secretary of HEW.

There are two options, and only two, now available to physicians: (1) Peer Review, under PSRO; (2) HEW review, under direction of the Secretary of HEW.

A PSRO manual, with the first guidelines developed by HEW, was released in March 1974. The guidelines allow some flexibility in the way of implementing the review procedures, but in general follow the directives as previously understood under the law. Several areas might be worthy of comment:

1. Fiscal agents of Medicare and Medicaid will continue to determine eligibility, definition of coverage, and appropriate charges, in the same way that they now perform these functions. The PSRO will be responsible for utilization review and medical audit. Concurrent review and recertification procedures will eliminate any retrospective review leading to denial of payment. The physician must be notified within two days of any hospital treatment which is considered inappropriate.

2. The current requirements of the Joint Committee on Accreditation of Hospitals requires precisely the same functions as are required in the PSRO guidelines, performance of its own review under delegation from the PSRO.

3. PSRO review services will be maintained and operated by hospital medical staffs as long as they demonstrate capability and willingness to perform these functions. Where PSRO is operating effectively, the HEW Secretary will waive all other review requirements by Medicare and Medicaid intermediaries.

4. Considerable flexibility will be allowed each hospital in establishing its review procedures. It must be shown only that the services being rendered are "necessary, appropriate, and meet acceptable professional standards."

5. The PSRO is required to perform profile analyses of physicians, patients, hospitals and diagnoses.

6. Initially, concurrent admission certification and recertification are required. As profiles are developed, physicians and hospitals can be identified which do not require this certification, and they will be exempt.

7. Emergency admission certification, initially, must be done on all admissions, or on a significant random sampling. Later, certain providers will be exempt as in the case of concurrent review and recertification.

8. Discharge planning should be instituted shortly after admission. It must be shown that the physician is aware in his planning of the type of facility, if any, from which the patient came, the type of continuing care he will need, and the availability of appropriate facilities for his care after discharge from the hospital.

9. Nonphysician practitioners will be reviewed by peers under supervision and consultation of PSRO committees.

It is still unnecessary to make a final decision regarding implementation of a Professional Standards Review Organization under MAG auspices. A plan is not yet available. Development of such a plan will require an estimated six to nine months. After the plan has been developed, it can be submitted to HEW for approval only after a confirmative vote of the MAG House of Delegates. The individual practicing physician will still have a final opportunity to choose whether or not to participate in the PSRO. Should the MAG delegates approve, and the HEW accept a PSRO plan, it can be rejected by a majority vote of practicing physicians in the PSRO area.

In its deliberations, the chairman of the PSRO committee submitted the following recommendations for committee consideration and vote:

1. Send a resolution from the House of Delegates to Sen. Herman Talmadge, thanking him for his rather extensive and successful endeavors in obtaining single area designation for Georgia. This was approved by a substantial majority of the committee.

2. Follow the progress of the repeal movement in the various states, but at this time discontinue the organized and expensive campaign by MAG to influence Congress to repeal the law. Effectively, "repeal" can be accomplished by refusal to participate, making congressional repeal unnecessary. This recommendation was rejected by a substantial majority of the committee.

The majority opinion was that MAG has committed itself to work for repeal and should continue to do so as long as there is any hope that this can be accomplished. The majority feels that there are encouraging signs of increasing support in Congress for the repeal movement. The majority did not agree that non-participation would accomplish the same ends, primarily because it was felt that a much more extensive and costly bureaucracy would be required under PSRO than would be necessary if the Department of HEW operated the system directly.

The dissenting viewpoint is that the encouragement is really only wishful thinking, and that those experienced at tabulating votes in Congress can see no more than 100 votes in the House and very few votes in the Senate. The continued aggressive efforts at repeal will only alienate Congress and minimize the effectiveness of the profession in offering constructive advice on the vitally important National Health Insurance issue.

3. By resolution of the House of Delegates, endorse the efforts of AMA to amend the PSRO law in areas identified by the AMA Council on Legislation and PSRO Study Committee. Forward these resolutions to the AMA House of Delegates. Concentrate the efforts of MAG at this time toward convincing the Congress that these elements of the law must be removed by amendment.

A substantial majority of the committee rejected this recommendation. They adopted instead the report and recommendation of the Subcommittee on Amendments:

After considerable discussion it was the unanimous opinion of the Subcommittee on Amendments that there should be no recommendations concerning en-

dorsement or approval of the current amendments as listed by the American Medical Association. The Subcommittee also felt that no further attempts at amending would be pertinent to the issue at hand. It was the stated opinion of the group at the Subcommittee meeting that the opposition to the PSRO law should be complete and without modification.

Therefore, it is the recommendation of the Subcommittee to the full PSRO Committee and to the MAG House of Delegates that MAG stand unalterably for repeal without attempted modification since we feel that this compromises our philosophical objections to the law.

The dissenting position is that an adamant, uncompromising position does not represent responsible leadership, particularly when such a position tends to jeopardize the welfare of the profession. Objective evidence indicates little chance for repeal. There are certain aspects of the law which are unacceptable to the practicing physician, and these portions can very probably be eliminated by amendment.

4. Apply to the HEW for a planning contract, now available, to provide funds to continue to study and develop a plan under the PSROG which could be used as a statewide professional standards review organization for Georgia. This would not require the MAG House of Delegates to accept the plan. The House would have an opportunity to vote on this at a regular or called meeting. It would allow continued work on the problem, which will require a considerable amount of time, and this further undertaking could be performed with federal funds rather than with MAG funds. If the contract application is not made at this time, it will not be possible to make an application until the next fiscal year in mid-1975. Thus, there might not be time to complete a plan before the deadline of January 1, 1976, set in the law.

This recommendation was rejected by substantial majority of the committee. Their viewpoint was that the application for a planning contract would jeopardize the efforts of those working for repeal by presenting an inconsistent position to Congress.

The dissenting minority stated that this is practical politics and that 70 of the 203 PSRO areas are now in the process of planning, many of which are in states still working for repeal. It is always good policy to be prepared. The membership will *not* be committed to the program and will have two subsequent opportunities to vote it down, first through representatives in the MAG House of Delegates and later as individual practitioners throughout the state.

In view of the decisions by the committee, significant questions remain to be answered, in the opinion of the chairman:

1. What hard evidence is available that there is a chance to repeal PSRO? How many votes are committed?

2. What alternative do we offer, should repeal efforts succeed? The Secretary of HEW is empowered to, and required to, institute nationwide review systems for federally funded programs, and only PSRO offers a peer review mechanism. Are we choosing to have the quality of care and appropriateness of physicians' services judged by appointees of HEW rather than by peers?

3. If we delay efforts to amend the law, and repeal efforts fail, will we not then have to accept all of the onerous aspects of PSRO, some of which we might succeed in removing by appropriate amendment of the law? Would we not then be left with a system essentially the same as we will have to operate anyway to achieve JCAH accreditation?

4. Are we wise to devote all our efforts toward repeal of PSRO, when the most threatening of all the National Health Insurance proposals, The Kennedy-Mills bill, is now before the Congress and needs our urgent consideration? If Congress agrees to extend its obligation to finance medical care for a larger segment of the population, is it likely to be willing to accept a program of reduced control?

5. Is it prudent policy to delay the planning of a complex mechanism which will probably be required, and perhaps lose control to some outside agency by default, especially when it does not demand any commitment from us at the present time?

6. Even with grave misgivings as to the possibility of PSRO functioning successfully, are we willing to let it fail without a conscious effort by the profession? Would the resulting massive chaos not encourage expansion, rather than reduction, of government controls?

7. Is it not certain that we would already be working under a review system directed by the Secretary of HEW, had not the AMA interceded successfully in 1970? Will we be granted another such opportunity?

8. Does mature judgment not require that we forego the impulse of the moment for our future well-being? Would a decision to reject the opportunity to operate and control a peer review mechanism, voluntarily surrendering one of the few chances for professional independence still allowed us, represent mature judgment and responsible leadership?

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee recommends the filing of this report for information. The Chairman of the PSRO Committee is to be commended for the time that he has devoted and the effort that he has put in to his analytical study of the PSRO Law. His efforts to inform the MAG members on the provisions of the PSRO Law are greatly appreciated by us all.

HOUSE OF DELEGATES ACTION—Accepts the report on the basis of the recommendation by the Reference Committee that this report be filed for information.

SUPPLEMENTAL REPORT 74-8 OF COMMITTEE ON PSRO

John P. Heard, M.D., Vice Chairman

Since receiving its charge from the Executive Committee of Council in February 1974, the full committee has convened twice, subcommittees meeting separately to handle more individual tasks. The committee has met with representatives of outside public relations firms and discussed the problems of implementation of the program for repeal that was initiated by the House of Delegates in December 1974. We have been appraised of the continuing efforts of Executive Committee of Council and MAG staff to develop and implement the movement to repeal the PSRO law. The committee has applauded the activities as demonstrated by:

1. Congressional contacts. Through these efforts nine

of the 10 Georgia Congressmen have committed themselves to vote for repeal while the tenth has not taken a position. One of our Senators is committed to PSRO while the other has stated that he is studying the issue.

2. Educational material. Our MAG staff has developed and distributed brochures, tent cards, and bumper stickers urging repeal of PSRO. Various members of the committee have appeared in the Communications media explaining PSRO and urging the public to pressure for repeal.

3. Repeal rally. Through continued efforts a very successful meeting was held in Atlanta on April 7 with approximately 400 people in attendance. This included representatives from 13 states and featured speakers of national prominence.

It is also of note that MAG requested and received considerable assistance from Senator Herman Talmadge to reclassify Georgia as a single statewide PSRO area. Other Washington actions have been the introduction of over 30 bills to repeal PSRO into the House of Representatives and at least two bills into the U. S. Senate. All of this has occurred within the past six months and would seem to indicate a growing force for the repeal movement.

This committee has followed its charges by

1. continuing to study the implication of PSRO law including an exhaustive study of the PSRO Program Manual concerning the specific activities of a PSRO agency;

2. developing an alternate plan by evaluating the mechanisms of review available from EMCRO, TAP Institutes and the activities of the Georgia Medical Care Foundation;

3. studying the amendments suggested by the AMA Council on Legislation in order to realize those areas of the law that might be open to modification;

4. reviewing the application to HEW for a planning contract to develop formal plans necessary to qualify as a conditional PSRO.

After considerable discussion and debate covering the areas described above the Committee has reached the following conclusions:

1. MAG should continue its efforts for repeal of PSRO law. We are in the midst of an extensive campaign that has achieved national prominence, and we are being looked to for guidance and direction within the repeal movement. It is imperative to supply whatever assistance we can to assist the other state medical associations in joining our efforts.

2. There are viable alternatives to participation in PSRO-type activities, regardless of the source of authority for these activities. These include methods of medical audit involving the individual hospital medical staffs in retrospective quality care review, thus doing true "peer review."

3. The suggested amendments to the law did not appear to alter the major thrust of the PSRO law, and the subcommittee felt that we should not support efforts to amend because this would compromise our philosophical objections to the law.

4. The application to HEW for a planning contract appears to be premature. No absolute deadline for applications to HEW has been announced. Drawing up formal plans to be a conditional PSRO leaves anyone with the impression that MAG is willing to implement PSRO. The previous position of the House of Delegates has been that PSRO is ill-conceived law and will prove detrimental to the patient, the physician and the government. The committee reaffirms this position, and therefore feels that MAG should not be involved in this type of activity.

Therefore, we would like to make the following recommendations to the House of Delegates:

1. Continue to vigorously work for repeal of PSRO. Expand our activities to reach the public with speeches and public service programs. Maintain an active liaison with the other state medical associations to coordinate activities.

2. Instruct Council, Executive Committee of Council and/or MAG staff to withdraw the application to HEW for a planning contract to develop plans to qualify as a PSRO.

3. Communicate the above decisions to the AMA House of Delegates, the various state medical associations and our Congressional representatives making the issue perfectly clear as to MAG's position on PSRO.

4. Instruct our AMA delegation to

(a) Maintain a clear, unencumbered position for repeal of PSRO,

(b) Prepare and introduce appropriate resolutions at the AMA convention in June, 1974, calling for AMA to establish a concise, stable position for repeal of PSRO and to cease and desist from further efforts to implement or amend what has been generally accepted as a bad law.

5. Continue to explore the methods of true peer review under the auspices of the local hospital medical staff and/or local medical society, including the possibility of adapting review systems to assist in these procedures.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval of this report as amended with commendation. Recommendation 1 is amended to read "Continue to vigorously work for repeal of PSRO. *Continue* our activities to reach the public with speeches and public service programs. *Expand liaison activities* with the other state medical associations to coordinate *activities to repeal PSRO.*"

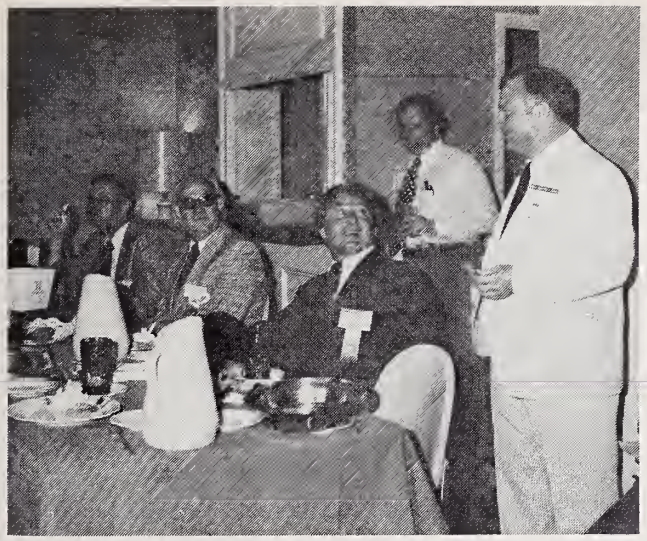
In reviewing the success of the repeal PSRO Program in Georgia, it was the considered opinion of your Reference Committee that the other state associations be made aware of the MAG success. Such liaison will hopefully, provoke substantial response, especially in the contacting of their congressional delegations.

Recommendation 2 is recommended for approval.

Recommendation 3 is amended to read "Communicate the above decisions to the AMA House of Delegates, the various state medical associations and our congressional representatives making the *issue clear* as to MAG's position on PSRO."

The Committee recommends approval of Recommendation 4.

Your Committee recommends approval of Recommendation 5 as amended to read as follows: "Continue to explore the methods of true peer review under the auspices of the local hospital medical staff, local medical society, *and the MAG, as well as the Medical Care Foundation. A genuinely viable alternative should be aggressively pursued not only because of governmental processes but because the medical pro-*





The hows and whys of reference committee work are explained in a luncheon meeting attended by (L-R) Vice Speaker L. C. Buchanan, R. J. Moye, J. H. Smith, staff members Charlie Templeton and James Moffett; Questions on PSRO are fielded by HEW representative John Farrell (R) as members of Reference Committee C listen intently.

fession in Georgia continues, as always, to desire to maintain the highest standards of quality in all aspects of patient care. It is recognized that unparalleled progress has already been made in peer review programs in Georgia by organizations such as the Medical Care Foundation through its CHEC mechanism. It is recommended that such mechanisms be subjected to intensive scrutiny by a special force to be appointed by Council; perhaps an established group with an already highly developed level of expertise and capability such as the existing PSRO Committee, would be appropriate for such a task. This organization should report to the annual meeting of the House of Delegates in 1975."

At this time your Reference Committee wishes to comment further on this issue, vital not only to ourselves but to our patients. In order to be certain that our intentions in opposing and seeking the repeal of the PSRO Law are understood by Congress and by our patients, your Reference Committee believes that certain issues should be clarified. In seeking repeal of the PSRO legislation, the MAG membership does not seek to shirk its responsibility for accountability for federal funds spent in the Medicaid and Medicare programs. We firmly believe that a better mechanism for providing accountability can be developed and that the physicians themselves should be the ones to develop it. The concept of peer review was developed by physicians, not by HEW, and as noted in Recommendation 5 of the Supplemental Report of the Committee on PSRO, there should be continued exploration of various methods of peer review. Included in this should be a consideration of adapting current review systems, such as, the Foundation, CHEC and JCAH's TAP as alternative mechanisms to the PSRO Law.

In vigorously working for repeal of the PSRO Law, we do not deny the need for quality of care assessment. Indeed, we reaffirm our commitments to quality of care assessment and re-emphasize the importance of performing utilization review at the local level and we concur with the necessity for assessment of appropriateness of care provided to patients, as performed by the local hospital medical staff and/or local medical society. Further, we rededicate ourselves to the concept of quality of care by reaffirming our commitment to continuing medical education.

Your Reference Committee recommends the addition of a sixth recommendation to this report to read as follows:

6. Recognizing that sudden illness and/or accident of true catastrophic magnitude can quickly reduce most citizens to fiscal insolvency, loss of dignity, respect, and self-sufficiency, we recommend that MAG formally declare its belief that some system of cost underwriting protection should be devised for those Americans confronted with such a situation. We believe, it is not contradictory to our continuing dedication to the American principles of self-sufficiency, individual provisions for one's own usual needs and private enterprise to advocate government provision of this type of overriding financial coverage and MAG should take the initiative in working with our legislators in developing such a system.

HOUSE OF DELEGATES ACTION—A floor amendment proposed by delegate Charles Todd, seconded by delegate F. William Dowda change the last sentence in this supplemental report to read as follows: "We believe that it is not contradictory to our continuing dedication to the American principles of self-sufficiency, individual provisions for one's own usual needs and private enterprise to advocate provision of this type of overriding financial coverage and MAG should take the initiative in working out the details in development of such a system." This floor amendment was adopted. The House then adopted the supplemental report of the Committee on PSRO as extensively amended by the Reference Committee.

RESOLUTION 74-4 ACCEPTANCE OF PSRO PLANNING CONTRACT

Charles D. Hollis, M.D., in behalf of the Dougherty County Medical Society

WHEREAS, there is considerable concern among members of the MAG regarding the possibility of con-

tinuing the independent practice of medicine under increasing Federal Controls, and

WHEREAS, some method of review of services must be provided to assure accountability under Federally funded programs, and

WHEREAS, the Social Security Act creating Medicare and Medicaid established such a method, whereby the HEW would develop a review system manned by teams of physicians, health care workers and consumer representatives appointed by HEW, and

WHEREAS, Congress, upon the insistence of organized medicine provided an alternate method under legislation known as PSRO, by which the review procedures would be operated only by practicing physicians and osteopaths, rather than by HEW appointees, and

WHEREAS, the only option available to practitioners is the choice between review by HEW and review by peers, and physicians in Georgia are committed to accept review only by their peers, and,

WHEREAS, the HEW has recently designated Georgia as a single PSRO area, through which the process can be expedited and the operation performed by an arm of the MAG, primarily in consideration of the success of the medical care foundations in Georgia and the strong support of Senator Herman Talmadge, and

WHEREAS, realizing the great expense involved in establishing plans for such a new and intricate operation, Congress has made available planning grants for groups of physicians attempting to set up such an operation, and

WHEREAS, the MAG has already spent considerable sums in PSRO activities, and

WHEREAS, only after such a plan has been developed, perhaps by December 1974, would members of MAG be required to vote approval or disapproval of the proposed organization, now

THEREFORE BE IT RESOLVED, that the MAG agree to accept a planning contract from HEW, thus making it possible to use Federal funds rather than MAG funds in further study of the PSRO program, and

BE IT FURTHER RESOLVED, that the MAG utilize these funds to prepare a mechanism whereby PSRO review procedures could be implemented statewide, if it should seem advisable for physicians to maintain control of the review process, and

BE IT FURTHER RESOLVED, that the MAG plan a called meeting for the House of Delegates in December 1974, or at such time as the plan has been completed, for a vote as to whether or not the MAG, through a subsidiary organization, should be sponsoring agent for a statewide PSRO, and

BE IT FURTHER RESOLVED, that the MAG simultaneously prepare specific proposals for amending the present PSRO law, removing the most undesirable aspects of the law as identified by the AMA Council on Legislation and the MAG Study Committee on PSRO, to be presented to the AMA House of Delegates and to representatives in Congress.

REFERENCE COMMITTEE RECOMMENDATION —The Reference Committee recommends disapproval of this resolution.

HOUSE OF DELEGATES ACTION—Adopted the report of the Reference Committee thus disapproving Resolution 74-4.

RESOLUTION 74-7
AMENDMENTS TO P.L. 92-603

Luther M. Thomas, Jr., M.D., for Richmond County Medical Society

WHEREAS, a program which denies payment for hospital care for insured patients has been initiated under the authority of P.L. 92-603, and other laws, without adequate explanation of the intent, mechanism, or method of the program; and

WHEREAS, the guidelines for denial of payment have not been made available, and the source of the guidelines is unknown, and

WHEREAS, initial denial of payment is made on the basis of review by personnel who are not physicians, who are not familiar with practice in the area in question, and who have no current experience in care of patients, and

WHEREAS, the decision of denial of payments is based to a large extent on the nurses notes in the record, now

THEREFORE BE IT RESOLVED, that the Richmond County Medical Society requests that the Medical Association of Georgia and the American Medical Association give support and assistance in efforts to publicize all aspects of this program, seek legal opinion on the validity of the laws supporting the program, and aid in an effort to amend the parts of any laws that allow this program, and request that this resolution be referred to appropriate committees of the Medical Association of Georgia and the American Medical Association for action at earliest possible date.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends disapproval of this resolution. Although the concept of this resolution was heartily endorsed by your Reference Committee, there was insufficient information and analysis of the problem available to the Committee. Your Reference Committee recommends referral of this question by the author of the resolution to the MAG Legislative Committee for its consideration and appropriate recommendations.

HOUSE OF DELEGATES ACTION—Adopted the report of the Reference Committee thus disapproving Resolution 74-7.

RESOLUTION 74-9
PSRO

W. John O'Shaughnessey, M.D. for the Bibb County Medical Society Delegation:

Jack F. Menendez, M.D.
F. G. Etheridge, M.D.
Jasper T. Hogan, Jr., M.D.
S. Charlotte Neuberg, M.D.
Charles A. Magnan, M.D.
Charles A. Duggan, M.D.
Beverly B. Sanders, M.D.

THEREFORE, BE IT RESOLVED, that since PSRO is designed to decrease hospital cost for Medicare and Medicaid patients by limiting hospital care, but *does not* control the rising hospital costs due to the effect of changing minimum wages, and,

Does not control inflation influence on rising hospital costs, and,

Does not limit the rising number of beneficiaries of Medicare and Medicaid coverage, and,

Does not regulate the additional procedures and treatments that these programs are assigned by the Government which result in higher costs, and,

Does not curtail the expansion of these programs into physio-therapy and chiropractic, and,

Does not induce incentives to the patients to limit excessive demands for medical care under these programs, and,

Thus, we hereby conclude that PSRO is inappropriately oriented in its effort to effect the rising costs of government medical expenditures for Medicare and Medicaid.

But more importantly, since we basically agree that it is wrong to impose a program on patients and physicians which makes it difficult to admit and care for hospital patients and jeopardizes the confidentiality and intent of the doctor-patient relationship, and,

Since involvement in such a program is thus directly contrary to the Code of Medical Ethics of the American Medical Association and the Medical Association of Georgia, we hereby state that we will in no way involve ourselves in the organizing of a Georgia Professional Standards Review Organization.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval with commendation of this resolution.

HOUSE OF DELEGATES ACTION—Adopted Resolution 74-9.

RESOLUTION 74-10
REPEAL PSRO

J. Kenneth McDonald, M.D., for Richmond County Medical Society

WHEREAS, at its December 1973 meeting, the House of Delegates of the Medical Association of Georgia voted to seek repeal of the Professional Standards Review Organization Act (PSRO); and

WHEREAS, the American Medical Association House of Delegates has stated that repeal of PSRO would be in the best interest of the health of the American people;

THEREFORE BE IT RESOLVED, that the House of Delegates of the Medical Association of Georgia direct its delegates and alternate delegates to the American Medical Association to actively work for and vote for resolutions initiating active efforts on the part of the American Medical Association to seek Congressional repeal of PSRO legislation.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval with commendation of this resolution.

HOUSE OF DELEGATES ACTION—Adopted Resolution 74-10.

Chairman Waters expressed his appreciation to the members of the Reference Committee for their time and effort and moved that the Reference Committee report be adopted as a whole as amended. This motion was duly seconded and approved.

REPORT OF REFERENCE COMMITTEE D

W. John O'Shaughnessey, M.D., Chairman

Chairman O'Shaughnessey reported to the House of Delegates that the reports and resolutions referred to Reference Committee D had been considered by the Committee which met at 1:00 p.m. in the Madison Room at the DeSoto Hilton Hotel, Savannah, Georgia, on May 10, 1974. Members of the Committee present included: W. John O'Shaughnessey, M.D., Macon, chairman; W. Jack Smith, M.D., Brunswick; Wells Riley, M.D., Jonesboro; Carey Mickel, M.D., Elberton; and John C. Hall, M.D., Atlanta.

COMMITTEE ON ANNUAL SESSION

Preston D. Ellington, M.D., Chairman

In May 1973 the MAG House of Delegates directed that the Scientific Session of the Medical Association of Georgia Annual Meeting would be coordinated through the Interspecialty Council, the MAG Committee on Education and the MAG Committee on Annual Session.

In September a Task Force Committee, composed of the Chairman of the Committee on Annual Session, and the Chairman of the Interspecialty Council, and the Chairman of the MAG Committee on Education met at MAG Headquarters to discuss the Scientific Session. Their recommendations were:

1. To hold a two-day Scientific Session in late October in Atlanta each year. The Task Force Committee recommended that the meetings be held on a Thursday and Friday but left the final decision to the Interspecialty Council.

2. That MAG's financial responsibility for this Session would be the payment for one out-of-state guest speaker's expenses and honoraria up to $300 per specialty society; and that contributions would be sought from pharmaceutical companies, with each specialty society being asked to pay any additional expenses over and above that allocated by MAG if other guest speakers are desired.

There was a meeting with the Interspecialty Council on November 11 and the specialty society representatives present were informed of recommendations as stated above. Most of these members could not approve this proposal without consultation with their specialty society members. Therefore, a letter was mailed to the members of the Interspecialty Council, and the presidents of the specialty societies, asking that each society consider this suggestion as the Annual Meeting for their specialty society.

From a list of 18 specialty societies represented on the Interspecialty Council there have been replies from all. All of the 18 there are: 6 for participation in 1974 (Chest, Dermatology, Neurosurgery, Ob-Gyn, Radiology, and Surgery); 4 will not participate (Family Practice, Otolaryngology, Urology and Orthopaedics); and 8 for participation in 1975 (Anesthesiology, Internal Medicine, Pathology, Pediatrics, Psychiatry, Ophthalmology, Public Health and Plastic Surgery).

RECOMMENDATION

That the Scientific Meeting not be held in 1974 but to continue to make a concerted effort to obtain a majority of participation by the 18 specialty society members of the Interspecialty Council for 1975. To qualify this recommendation, it will be necessary to make the contacts with the various specialty societies to give them the full details of the proposed format, explain the plans for MAG's assistance in financing guest speaker expenses, and to stress the importance of a good scientific meeting sponsored by the state association which would be well received by the membership. This would assist the MAG members in continuing education with the possibility in mind that this may be a requirement for relicensure in the future. The Annual Session Committee realizes that there are many scientific meetings held, and the Association's plans for a scientific meeting might well be "just another meeting," but with MAG staff working with the specialty society officers and representatives of the Interspecialty Council, and keeping in mind that the better the program the better the attendance, a concerted effort would be made to this end.

If the above recommendation is approved, the Committee will begin planning for 1975.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval with additional recommendations made by the Reference Committee itself.

The Committee strongly encourages the continued planning of a scientific session for the MAG in the fall of 1975; however the Reference Committee recommends that if after further research it is felt by the Chairman of the Interspecialty Council, the Chairman of the Committee on Annual Session, and the Chairman of the MAG Committee on Education that the proposed meeting will be unsuccessful, it is not required that MAG hold a scientific session in the fall of 1975.

HOUSE OF DELEGATES ACTION—Adopted the report of Committee on Annual Session as amended by the Reference Committee.

COMMITTEE ON MATERNAL AND INFANT WELFARE

Luella M. Klein, M.D.

In 1973 the Committee on Maternal and Infant Welfare met several times to review maternal deaths, discuss the GRMP study projects in areas of maternal and infant planning, and to discuss health legislation and regulations in the fields of abortion and maternal and infant care.

The Committee did not carry on its usual activities as often in 1973 as in the past due to the untimely death of Dr. Eugene L. Griffin, chairman of this Committee from 1959 to September 1973. He was held in deepest esteem and admiration for his devotion to the goals of the Committee and his loyalty to the Medical Association of Georgia.

LIVE BIRTHS AND BIRTH RATE

There were 87,366 live births in 1972. The birth rate decreased to 18.5 (20.7 in 1970). This decrease in birth rate was due to a decrease of the white live-birth rate from 18.2 in 1971 to 16.4 in 1972. The non-white live-birth rate decreased in the past year from 25.2 in 1971 to 24.5 in 1972. (Preliminary data indicates that there were approximately 90,000 live births in 1973.) Hospital deliveries reached a high of 98.1 per cent compared to a rate of 97.5 per cent in 1971. In 1971, more than 9,000 hospital deliveries were paid for under Medicaid (Title XIX).

MIDWIFE ACTIVITIES

There were 1,119 (1.3 per cent) live births attended by lay midwives in 1972.

MATERNAL MORTALITIES

There were 19 maternal deaths in Georgia in 1972 out of a total of 87,366 live births. The death rate of 2.2 per 10,000 live births represented a decrease from the 2.7 rate of 1971. The causes were abortion (two), pulmonary embolus (four), and other conditions of diseases of pregnancy or the puerperium (six), toxemia (four), ruptured uterus and other conditions during childbirth (three).

ABORTIONS

In calendar year 1972 there were 4,604 abortions reported to the Department of Human Resources. This amounts to about 55 abortions per 1,000 live births estimated for the year. It is noteworthy that up to January 31, 1973 there had been no "abortion" deaths reported for 1972. In 1971 Georgia had four maternal deaths related to abortion, six in 1970, and two in 1973. This indicates that the number of criminally induced abortions are being reduced since abortion has become legalized in the state.

IMMATURE BIRTHS

In 1972 there were 7,721 immature live births (494 less than in 1970) for a rate of 88.4 per 1,000 live births (increase from 87.9 in 1971). Immaturity at birth is twice as frequent in the nonwhite as in the white race (400 white, 859 nonwhite). It is also significant that immaturity occurs more frequently in live births to the mother under 18 in both races.

PER CENT OF IMMATURE LIVEBIRTHS, 1969 TO 1972

	1969	1970	1971	1972
White	7.0	7.1	6.6	6.7
Nonewhite	14.1	13.4	13.0	12.9
White under 18	9.9	10.0	9.1	8.6
White 18 to 39	6.8	6.9	6.4	6.4
Nonwhite under 18	16.3	16.0	15.5	15.7
Nonwhite 18 to 39	13.7	12.9	12.4	12.1

BIRTHS TO UNWED MOTHERS

There were 11,693 live births to unwed mothers, an increase of 356 over the previous year. The rate rose from 121.3 to 133.8 between 1971 and 1972. Live births to white unwed mothers (1,976) decreased and live births to unwed nonwhite mothers (9,717) increased 669 from the previous year. Immaturity at birth is significantly influenced by marital status both generally and racially.

LIVE BIRTHS TO GRAND MULTIPARA

A total of 3,716 live births (4.3 per cent) in 1972 were in the order of sixth and over, compared to 4,564 live births (4.9 per cent) in 1971. Since 1960 the per cent of first and second births to a mother has been increasing in both races. However, the per cent of births in the order of third or greater have shown significant declines. In 1970, 28 per cent of all white births were in the order of third and greater. In 1971 this had declined to 27.4 per cent. The percentage of third and greater order live births among the nonwhite had declined from 39 per cent in 1970 to 37 per cent in 1971.

PER CENT OF IMMATURE LIVEBIRTHS, 1969 TO 1972

	1969	1970	1971	1972
Married	8.6	8.3	7.9	7.9
Unmarried	14.4	14.5	14.1	13.8
White Married	6.8	7.0	6.5	6.5
White Unmarried	11.4	10.3	9.8	9.6
Nonwhite Married	13.6	11.2	12.1	11.8
Nonwhite Unmarried	15.2	15.6	15.0	14.7

ADOLESCENT PREGNANCIES

Live births to adolescents representing 24 per cent of all live births in 1971 have increased to 25.8 per cent of all live births in 1972. There were 10,120 live births to mothers under 18 years of age out of the total of 22,534 adolescent live births. Of live births to unwed mothers, 55.5 per cent were to adolescents. One out of every nine infants live-born to an adolescent is immature by weight at birth.

PERINATAL DATA REPORTING

Because of the recommendations of the committee and the Medical Association of Georgia relating to medical information to be obtained with the birth certificate, the Department of Human Resources has studied methods of obtaining confidential medical data and adopted a new Certificate of Live Birth which will meet the needs for vital registration as well as medical biostatistical analysis. The new certificate was inaugurated in July 1972.

FAMILY PLANNING

As of December 31, 1973, there were 71,000 women actively participating in the Department of Human Resources' Family Planning Program (1972—67,000). This number is based upon proven continuous active contraceptors by current records in the state data collection computerized evaluation system. The number is on the conservative side, as it does not include a large number of women who received services before the institution of the current record system and who may well be continuing as active contraceptors. During the fiscal year 1973 there was a total of 68,358 active patients (58,219 in 1972), served through 198,897 visits provided through Health Department clinics. Family planning services were provided to approximately 12,000 additional women through Medicaid. The greatest determent to more rapid expansion of this program has been the lack of sufficient physician time for services.

STATE ABORTION REPORTING SUMMARY FOR GEORGIA, 1968 TO 1973

(Abortions reported in accordance with the Georgia Abortion Law)

	Year End Totals					
	1968	1969	1970	1971	1972	1973
1. Number of abortions	73	168	701	1579	2509	4604
2. Number of live births	87322	90195	95584	93480	87366	90000
3. Deaths related to abortion	5	4	6	4	0	2
4. Race						
a. White	69	147	569	1036	1244	2510
b. Black	3	21	133	538	1253	2063
c. Other	1	0	1	5	10	27
d. Unknown	0	0	0	0	2	4
5. Age						
a. Less than 15	4	5	32	64	124	136
b. 15-19	5	42	172	418	749	1517
c. 20-24	12	41	161	429	705	1361
d. 25-29	25	36	151	258	428	782
e. 30-34	11	24	89	201	288	454
f. 35-39	11	11	67	140	152	277
g. 40-44	4	8	28	64	57	72
h. More than 45	0	1	3	5	6	5
i. Unknown	1	0	0	0	0	0
6. Weeks of gestation						
a. 8 or less	24	41	201	467	584	1420
b. 9-12	27	68	327	713	1132	2190
c. 13-16	13	26	74	162	303	317
d. 17-20	6	17	82	224	465	624
e. 21-24	1	3	16	8	23	45
f. 25 or more	0	1	1	4	2	7
g. Unknown	2	12	2	1	0	1

	Year End Totals					
	1968	1969	1970	1971	1972	1973
7. Marital status						
a. Single	21	86	394	831	1420	3030
b. Married	52	74	309	571	841	1348
c. Separated	0	2	0	89	74	71
d. Divorced	0	6	0	77	65	129
e. Widowed	0	0	0	9	12	17
f. Unknown	0	0	0	2	97	9
8. Number of living children						
a. 0	20	81	299	646	1013	2158
b. 1	7	34	99	254	496	952
c. 2	20	23	113	273	414	696
d. 3	11	15	112	212	292	424
e. 4	8	7	46	90	155	201
f. 5 or more	5	8	33	100	138	166
g. Unknown	2	0	1	5	1	7
9. Number of hospitals performing at least one abortion procedure	18	23	34	38	40	57
10. Number of counties with at least one resident abortion procedure	14	17	26	28	108	138
11. Number of physicians performing at least one abortion procedure	60	97	167	199	234	304

CERVICAL CANCER SCREENING PROGRAM

During fiscal year 1973, the Statewide Cervical Cancer Screening Program sponsored by the Georgia Department of Human Resources provided Pap smears to indigent and medically indigent patients receiving health services from local health clinics for over 74,483 women. Since the beginning of the program in 1967, approximately 236,003 Pap smears have been done, and a diagnosis of malignancy has been made in 494 cases. Eighty-seven per cent of the malignancies were preinvasive carcinoma of the cervix. Treatment of diagnosed cases has been provided by state assisted tumor clinics and by private physicians.

NUTRITION

The release of the report of the Committee on Maternal Nutrition of the National Research Council highlighted the health nutritional needs of pregnant women, especially those of the teen-ager. New concepts relating to proper weight gain, the non-routine restriction of sodium intake, and the importance of folic acid with iron were emphasized. Copies of the Summary Report are available to physicians serving obstetrical patients from the Nutrition Consultant of the Maternal Health Unit of the Department of Human Resources. The Maternal Health Unit has implemented inservice training programs related to the recommendations of the report at local levels for health and education personnel who in turn extend proper nutritional guidance and education of patients.

Four-fifths of the counties in Georgia have food stamp programs, and the present trend is toward more wide use of food stamp programs. Consumer education is vitally needed throughout the state to improve the buying skills of homemakers in order that the use of food stamps provides for adequate nutrition.

RECOMMENDATIONS

1. That the MAG continue to urge physicians of the state to make available even more of their time in family planning programs especially to the indigent and medically indigent people of the state. This program is the very foundation upon which maternal and infant care of the state must depend.

2. That the MAG go on record as deploring the increase in incidence of live births in adolescent mothers (25.8 per cent of all live births in 1972—10,120 live births to mothers 18 and under). That members of MAG attempt to reduce this by family planning, sex education in the schools and all appropriate means.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval with amendment to the report drafted by the Reference Committee itself. That Recommendation Number 2 be changed to read as follows: "That the MAG go on record as being aware that there is an increased incidence of immature live births and complications of pregnancies in mothers under age 18, and that members of MAG attempt to reduce this by family planning, sex education in the schools, and all appropriate means."

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Maternal and Infant Welfare as amended by the Reference Committee.

COMMITTEE ON PHYSICIAN-LAWYER LIAISON

T. A. Sappington, M.D.

The Committee on Physician-Lawyer Liaison met on February 16, 1974. I acted as temporary chairman of this committee.

Several problems as to fees were discussed. A suggestion had been received that a Medico-Legal Arbitration Committee be set up to work with local bar associations regarding future malpractice suits. It was felt by this committee that such a committee would not be feasible.

RECOMMENDATION

It is strongly recommended that each county medical society should arrange for a joint meeting with the local bar association at least once a year. The best place to iron out problems that do arise is at the local level. A format for such a program is being formulated.

As chairman of this committee, I was embarrassed that only one other M.D. attended this meeting, while five lawyers took the time and trouble to attend the meeting on February 16, 1974. Attendance of more M.D.s at future committee meetings is not only urged, but it is imperative.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval with amendment to the report drafted by the Reference Committee itself.

That the recommendation be altered to read as follows: "It is strongly recommended that each county medical society consider arranging a joint meeting with local bar association at regular intervals." We recognize that the best place to iron out problems is at the local level. A format for such a program is being formulated.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Physician-Lawyer Liaison as amended by the Reference Committee.

COMMITTEE ON PUBLIC HEALTH

J. Gary Palmer, M.D.

The members of the Committee on Public Health were appointed in January 1974. The first organizational meeting was held March 3, 1974 at the Medical Association of Georgia Headquarters. The Committee felt that the most outstanding public health problem facing the people of Georgia, at the present time is the rising incidence of venereal disease, particularly among the 16 to 25 year age group.

While many other public health problems exist in Georgia, to divert the Committee's efforts to more than one field initially, would be to dilute their effectiveness. It was, therefore, decided to organize an Anti-VD Campaign.

This campaign would be organized along two basic lines. First, physician education as to diagnosis, newer methods of treatment, and reporting for follow-up and case finding. Second, a campaign to increase public awareness of the symptoms of venereal disease and of available treatment.

RECOMMENDATIONS

The Committee on Public Health makes the following recommendations to the House of Delegates:

1. Recommendation regarding increasing physician responsibility toward VD:

It is apparent that the physicians of Georgia are failing to report and follow-up cases of VD seen in their offices. It is also apparent that all physicians may not be aware of the latest methods of diagnosis and treatment.

It is recommended that this Committee proceed with the development and dispersal of educational materials to the physician. This will require developing graphic and visual displays to be presented to county medical and similar scientific meetings; also, all members would receive printed material outlining diagnostic, therapeutic, and reporting procedures of VD cases. A brochure of this type will include information concerning availability of diagnostic materials, which may be obtained free from the Public Health Centers. Newer therapeutic techniques, involving drug choice and dosage, as well as follow-up, will be included.

Lastly, the need for case reporting to county public health centers for case finding will be stressed.

2. Public education campaigns designed to increase awareness of VD symptoms and availability of treatment:

Much of the public apathy toward VD is the result of ignorance and fear. An effective educational campaign designed to reach those age groups most commonly involved is proposed. This will require the production of static and mobile displays which will be placed in high density areas of the age groups involved. Well designed visual displays, demonstrating symptoms and outlining available treatment will be presented, without moralizing. These displays may be transported to various areas, such as college campuses, high schools, and other gathering places of young people.

A program is to be developed utilizing the media, with television and radio spots advertising symptoms and available treatment. A state sponsored "hot-line" is available, whereby individuals can get information about VD treatment by calling a specified number. This number will be widely published on radio, television, and in the newspaper.

A graphic display is currently being developed by members of the Committee with the help of the Division of Physical Health. Hopefully, this display will be completed in time to be set up for viewing at the meeting of the House of Delegates.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval with additional recommendations made by the Reference Committee itself.

That we recognize there is a moral problem entwined with VD and that physicians be encouraged to express themselves in a manner they individually choose regarding the moral breakdown which has resulted in the increased incidence of VD.

HOUSE OF DELEGATES ACTION—Adopted the report of the Committee on Public Health as amended by the Reference Committee.

DR. JOHN P. HEARD'S CANDIDACY FOR A POSITION ON THE AMA BOARD OF TRUSTEES

LaMar McGinnis, M.D., in behalf of the DeKalb County Medical Society

WHEREAS, there is a vacancy now existing on the American Medical Association's Board of Trustees, and

WHEREAS, the MAG Executive Committee and Council have unanimously endorsed the candidacy of Dr. John P. Heard to fill this vacancy, and

WHEREAS, Dr. Heard has played a domniant role on both the national, state, and local level in the struggle for repeal of PSRO and,

WHEREAS, Dr. Heard has conclusively demonstrated his leadership capabilities and his ability and desire to be an effective spokesman for the grass roots physicians, and

WHEREAS, Dr. Heard has proven his qualifications for this responsible position by his thorough knowledge of medical affairs and his organization and administrative abilities, and

WHEREAS, his election would greatly enhance the efforts to unify organized medicine to meet the challenges ahead, therefore,

BE IT RESOLVED, the House of Delegates of the Medical Association of Georgia enthusiastically supports the candidacy of Dr. John P. Heard for a position on the AMA Board of Trustees and therefore,

BE IT FURTHER RESOLVED, that this endorsement be transmitted to each delegate, alternate delegate, president, and executive director of each state medical society and metropolitan county medical societies.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee recommends approval and commendation.

HOUSE OF DELEGATES ACTION—Adopted Resolution 74-2.

Chairman O'Shaughnessey expressed his appreciation to the members of the Reference Committee for their time and effort and moved that the Reference Committee report be adopted as a whole. This motion was duly seconded and approved.

REPORT OF REFERENCE COMMITTEE F

Duane Blair, M.D., Chairman

Chairman Blair reported to the House of Delegates that the reports and resolutions referred to Reference Committee F had been considered by the committee which met at 1:00 p.m., in the Center Ballroom of the DeSoto Hilton Hotel, Savannah, Georgia, on May 10, 1974. Members of the Committee present included: Duane Blair, M.D., Decatur, chairman; Stuart H. Prather, Jr., M.D., Augusta, vice chairman; James H. Manning, M.D., Marietta; John S. Atwater, M.D., Atlanta; Robert D. Waller, M.D., Albany; and James H. Sullivan, M.D., Columbus.

SUPPLEMENTAL REPORT OF THE SECRETARY

Earnest C. Atkins, M.D.

I charge the Building and Land Committee with the responsibility of dealing temporarily with current space shortage in the MAG Headquarters Building until permanent plans can be implemented.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee approves the report and recommends that the needed space be leased.

HOUSE OF DELEGATES ACTION—Adopted the supplemental report of the Secretary.

TREASURER

Carson B. Burgstiner, M.D.

It has again been my privilege to serve the Medical Association of Georgia as your treasurer for the year 1973-1974. My second year in office has involved even more Council meetings, Executive Committee meetings, American Medical Association meetings and various committee meetings. Believe me, the staff and your fellow physicians attending these meetings are hard-working, self-sacrificing and dedicated to a more effective and efficient Medical Association of Georgia.

The financial position of your Medical Association continues to improve. Dues are coming in on schedule and there appears to be some increase this year. Our liquid funds have increased again this year over $100,000, largely due to reinvestment by Mr. L. B. Storey, Jr., our director of Finance and Dr. "Tex" Eldridge, our chairman of Finance. These funds have been earning interest rates from as high as 11 per cent to the present 8 per cent this year and are invested until needed for budgeted items. Our net worth should increase again when our audit for the year ending May 31, 1974 is presented.

It is difficult to evaluate and predict government programs these days, but it appears that the Georgia Regional Medical Program will continue to operate through 1974-1975. The Cancer Survey is scheduled to phase out January 30, 1974. EMCRO grant terminates on May 31, 1974; however, federal, state and local grants are good until 1976.

I would like to express my appreciation again to our Secretary, Dr. E. C. Atkins, for the unity he brings our staff and association.

Roses to Mrs. Catherine Wooten, whose untiring pace keeps us all on schedule and knowledgeable about what we are doing.

Our accountant and financial expert, Mr. L. B. Storey, Jr., whose wisdom, patience and zeal in looking for better interest rates continues to pay off.

These people on the MAG staff and fellow committee members, plus occasional advice from the "old tightwad," Dr. John S. Atwater, have helped your treasurer to solidify the financial position of MAG.

In these days of rising prices, inflation and the increasing threat to medical practice as we have known it, do something nice for yourself, *become active,* support your MAG with your time, your advice and your financial contributions.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee approves this report with commendation, and wishes to express its appreciation to Dr. Carson B. Burgstiner and Mr. L. B. Storey for the excellent job done in reinvestment of funds to secure the highest rate of interest.

HOUSE OF DELEGATES ACTION—Adopted the report of the Treasurer.

COMMITTEE ON FINANCE

F. G. Eldridge, M.D.

The Finance Committee will meet in conjunction with Reference Committee F and also with the President of MAG, the President-Elect, the Secretary, the Treasurer and the Chairman of Council on April 6, 1974 to formulate the budget for fiscal year 1974-1975.

At the January meeting of the Council of the Medical Association of Georgia, a request was made that Reference Committee F of the House of Delegates for the May meeting of 1974 be named at an early date so that they could meet with the Budget Committee and work out complete details regarding the budget for the fiscal year thus allowing adequate time for publication in advance of the meeting for appropriate study by the various committee Chairmen as well as members of the House of Delegates.

The Finance Committee is composed as follows:
Fleming L. Jolley, M.D., Atlanta
Remer Y. Clark, M.D., Marietta
F. G. Eldridge, M.D., Valdosta, chairman

Members of the Reference Committee F:
Duane Blair, M.D., Decatur, chairman
Stuart H. Prather, Jr., M.D., Augusta, vice-chairman
James H. Manning, M.D., Marietta
John S. Atwater, M.D., Atlanta
Robert D. Waller, M.D., Albany
James H. Sullivan, M.D., Columbus

C. E. Bohler, M.D., president, MAG
J. Rhodes Haverty, M.D., president-elect, MAG
Earnest C. Atkins, M.D., secretary, MAG
Carson B. Burgstiner, M.D., treasurer, MAG
David A. Wells, M.D., chairman of Council of MAG

Mr. L. B. Storey, Jr., Assistant Director of Business and Finance for MAG, will represent staff for this meeting.

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee approves the budget as submitted, showing an increase of 7.17 per cent over the 1973-74 budget, and notes with satisfaction that current expenses do not exceed income. Your Reference Committee commends the Finance Committee for the transfer of travel, postage and communications to the proper line items in the 1974-75 budget Your Reference Committee feels that the use of committee consultants represents services to the Association and not to a separate committee independent of the body of the Medical Association of Georgia. It is noted with pleasure that such funds for such consultants services have been transferred from individual committee budgets to the administrative budget. Your Reference Committee commends these several consolidations as realistic and hopes future finance committees will continue with this approach. Furthermore, an improvement in the budget is noted to be an increase in the funds budgeted for insurance

to provide benefits of $100,000. Accidental Death and Dismemberment insurance and $250.00 per week for a maximum of 400 weeks after one year has passed for permanent injury for all MAG members, and $50,000 Accidental Death Benefits for wives and Auxiliary members while traveling on MAG business. Staff is also covered by insurance coverage increases.

HOUSE OF DELEGATES ACTION—Adopted the report of the Finance Committee.

Summary-Comparison of Budgeted and Actual Operations

MEDICAL ASSOCIATION OF GEORGIA
Period: June 1, 1973 to April 30, 1974

	Budget 6/1/73 5/31/74	*Actual 6/1/73 4/30/74*	*(Over) Under Budget*	*'74-'75 Proposed Budget*
INCOME				
1. MAG Dues	$330,000.00	$349,580.00	$(19,580.00)	$350,000.00
2. Interest & AMA	14,000.00	43,699.41	(29,699.41)	26,000.00
3. FP Service	3,250.00	1,895.81	1,354.19	
4. Parking	7,000.00	4,375.00	2,625.00	6,000.00
5. *Journal*	49,000.00	31,539.38	17,460.62	42,000.00
6. Contingent—Transfer from Operating Capital	69,800.00		69,800.00	89,717.00
TOTAL INCOME	$473,050.00	$431,089.60	$ 41,960.40	$513,717.00
EXPENSE				
1. Fixed Allotments	$104,253.00	$ 74,840.31	$ 29,412.69	$123,360.00
2. Association Office	215,579.00	185,821.87	29,757.13	219,333.00
3. Association Committees	61,293.00	37,792.98	23,500.02	58,455.00
4. Related MAG Activities	4,425.00	3,081.94	1,343.06	19,075.00
5. Executive Committee Discretionary Fund	1,800.00	162.43	1,637.57	10,000.00
6. Contingent—Fund for use of Council from Operating Capital	10,000.00	37,451.46	(27,451.46)	10,000.00
7. *Journal*	58,100.00	55,656.64	2,443.36	54,894.00
8. Depreciation				
Building	15,000.00	13,750.00	1,250.00	15,000.00
Equipment	2,600.00	2,383.50	216.50	3,600.00
TOTAL EXPENSE	$473,050.00	$410,941.13	$ 62,108.87	$513,717.00
CASH AVAILABLE	*4/30/74*	*4/30/73*		
C & S Checking Account	$ 83,152.90	$ 56,040.23		
C & S Certificates	509,702.39	456,074.81		
TOTAL	$592,855.29	$512,115.04		
Restricted Funds included in Cash Available				
Regular	$ 30,000.00			
Building Depreciation	49,600.00			
Equipment Depreciation	2,400.00			
	$ 82,000.00			
1. FIXED ALLOTMENTS				
Interest on Mortgage	$ 39,495.00	$ 33,453.75	$ 6,041.25	$ 38,295.00
Retainers—Legal, Insurance, Actuary, Other	14,000.00	11,737.62	2,626.38	21,500.00
President's Honorarium	2,400.00		2,400.00	2,400.00
Annual Audit	2,700.00	2,700.00		2,900.00
Taxes	21,800.00	11,704.91	10,095.09	22,000.00
Retirement Contribution	9,908.00	7,870.49	2,037.51	11,915.00
Retirement Trust Fee	250.00		250.00	250.00
Woman's Auxiliary	10,500.00	7,737.54	2,762.46	14,900.00
MAG Foundation	3,200.00		3,200.00	3,200.00
MAG Roster				6,000.00
TOTAL FIXED ALLOTMENTS	$104,253.00	$ 74,840.31	$ 29,412.69	$123,360.00

	Budget 6/1/73 5/31/74	Actual 6/1/73 4/30/74	(Over) Under Budget	'74-'75 Proposed Budget
2. ASSOCIATION OFFICE				
Salaries	$182,930.00	$162,624.94	$ 20,305.06	$187,940.00
Insurance & Bonds	8,500.00	7,984.32	515.68	15,318.00
Payroll Tax	9,094.00	7,414.48	1,679.52	10,075.00
Travel—President	2,000.00	2,151.59	(151.59)	2,500.00
Travel—Past President	1,250.00	355.27	894.73	1,700.00
Travel—President-Elect	1,250.00	977.56	272.44	1,200.00
Travel—Office	12,000.00	10,160.99	1,839.01	21,000.00
Travel—Ex. Comm.	2,200.00	2,094.86	105.14	2,200.00
Travel—Delegates and Secretary to AMA	5,200.00	5,190.27	9.73	
Travel—Alternate Delegates and Treas. to AMA	4,800.00	2,825.77	1,974.23	
Macon Office Rent	1,440.00		1,440.00	
Maintenance—Building	2,750.00	6,212.27	(3,462.27)	3,600.00
Maintenance—Equip.	1,000.00	1,036.13	(36.13)	1,200.00
Telephone	8,600.00	8,825.67	(225.67)	7,200.00
WATS Line				3,600.00
Postage	7,000.00	6,441.26	558.74	8,400.00
Office Supplies	6,000.00	2,783.93	3,216.07	6,000.00
Janitorial, Supplies and Security	8,200.00	7,454.63	745.37	9,200.00
Meetings	1,800.00	1,165.89	634.11	1,800.00
Dues and Subscriptions	765.00	733.87	31.13	1,000.00
Utilities	10,000.00	11,299.86	(1,299.86)	13,200.00
Sundry	200.00	95.14	104.86	200.00
Equipment	3,600.00		3,600.00	12,000.00
	$280,579.00	$247,828.70	$ 32,750.30	$309,333.00
Less Reimbursable Expense	65,000.00	62,006.83	(2,993.17)	90,000.00
TOTAL ASSOCIATION OFFICE	$215,579.00	$185,821.87	$ 29,757.13	$219,333.00
3. ASSOCIATION COMMITTEES				
	$ 7,375.00	$ 5,049.02	$ 2,325.98	$ 6,050.00
Annual Session—Business Scientific	2,550.00		2,550.00	
Emergency Medical Service	250.00	234.22	15.78	300.00
Awards	400.00	363.81	36.19	400.00
Communications	21,920.00	12,703.76	9,216.24	26,875.00
Education	2,823.00	1,505.15	1,317.85	2,400.00
Ins. & Economics	2,550.00	2,542.00	8.00	675.00
Legislation—State	10,000.00	11,058.22	(1,058.22)	7,055.00
National				3,600.00
Medicine & Religion	150.00		150.00	
Peer Review	825.00		825.00	125.00
Mental Health				400.00
Quackery	6,500.00	362.62	6,137.38	2,200.00
Occupational Health				100.00
Rural Health	1,450.00	399.88	1,050.12	1,125.00
PSRO				2,650.00
School Child Health	1,500.00	574.30	925.70	800.00
Public Health				700.00
Contribution to GaMPAC	3,000.00	3,000.00		3,000.00
TOTAL ASSOCIATION COMMITTEES	$ 61,293.00	$ 37,792.98	$ 23,500.02	$ 58,455.00
4. RELATED MAG ACTIVITIES				
Delegates & Secretary Travel to AMA Meetings				$ 7,300.00
Alternate Delegates and Treasurer Travel to AMA Meetings				7,300.00
AMA Delegates Group Costs:				
Breakfasts	$ 1,000.00	$ 877.85	$ 122.15	1,200.00
MAG Suite and Hospitality	1,300.00	1,173.95	126.05	1,000.00
Southeastern Hosp.	900.00	676.00	224.00	1,000.00
Interprofessional Council	125.00		125.00	125.00
SAMA	500.00	234.79	265.21	500.00
SAMA—MAG Annual Sess.	450.00		450.00	450.00
State Medical Education	150.00	119.35	30.65	200.00
TOTAL RELATED ACTIVITIES	$ 4,425.00	$ 3,081.94	$ 1,343.06	$ 19,075.00

	Budget 6/1/73 5/31/74	Actual 6/1/73 4/30/74	(Over) Under Budget	'74-'75 Proposed Budget
5. EXECUTIVE COMMITTEE				
Discretionary Fund	$ 1,800.00	$ 162.43	$ 1,637.57	$ 5,000.00
Committee Contingent Fund				5,000.00
TOTAL	$ 1,800.00	$ 162.43	$ 1,637.57	$ 10,000.00
6. CONTINGENT FUND				
(For Council to Spend Where Items Not Budgeted)	$ 10,000.00			$ 1,000.00
Ins. Comm.—Glenn		$ 1,000.00		
Carpenter Move		704.05		
Realty Appraisal		1,000.00		
PSRO		2,178.00		
Buchanan, Rogers, Dowda PSRO Travel		1,217.90		
Dr. Barrow Travel		89.32		
Special Session		3,112.60		
Interest on Tax		720.99		
AASME—Biloxi		172.41		
TAP Institute		248.62		
Leadership Conference		472.21		
Dr. Heard's Campaign		875.12		
AAFMC Meeting		494.91		
TOTAL CONTINGENT		$ 12,286.13	$ (2,286.13)	$ 1,000.00
Repeal PSRO	$ 60,000.00			
Travel		$ 5,914.65		
Printing & Supplies		7,111.03		
Postage		319.66		
Xerox		484.65		
Public Relations		7,835.34		
GaMPAC Contribution		2,500.00		
Speaker		1,000.00		
TOTAL REPEAL PSRO		$ 25,165.33	$ 34,834.67	
TOTAL CONTINGENT AND REPEAL PSRO		$ 37,451.46		
7. JOURNAL				
Printing	$ 40,500.00	$ 38,537.45	$ 1,962.55	$ 35,803.00
Salaries	11,800.00	10,914.83	885.17	12,504.00
Insurance	750.00	646.93	103.07	994.00
Payroll Tax	850.00	709.03	140.97	883.00
Engraving & Cuts	2,025.00	2,984.53	(959.53)	2,325.00
Postage & Copyright	1,700.00	1,475.70	224.30	1,860.00
Clipping Service	175.00	137.22	37.78	175.00
Addressograph & Supplies	250.00	250.95	(.95)	300.00
Sundry	50.00		50.00	50.00
TOTAL JOURNAL	$ 58,100.00	$ 55,656.64	$ 2,443.36	$ 54,894.00

AD HOC COMMITTEE TO STUDY BUILDING AND LAND

F. G. Eldridge, M.D.

Several years ago when there was availability of funds for renovation, remodeling and enlarging MAG Headquarters, this was accomplished and with the advent of the various governmental programs such as CHAMPUS, Georgia Regional Medical Program, Georgia Medical Care Foundation and EMCRO Projects, the available space in the building has been inadequate to house all of these programs and projects.

Adjacent to our present MAG Headquarters, there is a corner lot with approximately 37,000 square feet which is being used for a parking lot at the present time.

This property is available for a price and the Council at the January 1974 meeting has allowed the Ad Hoc Building and Land Committee to negotiate for this property with certain specified conditions and at the present time the Committee is attempting to work out a reasonable purchase price and purchase agreement with the owners.

A full report will be presented to the House of Delegates at the Annual Meeting in May 1974.

Members of this Committee are:
F. G. Eldridge, M.D., Valdosta, chairman
Carson B. Burgstiner, M.D., Savannah
H. Duane Blair, M.D., Decatur

REFERENCE COMMITTEE RECOMMENDATION —Your Reference Committee accepts with approval the verbal report of this ad hoc committee. The recommendations of this committee were discussed at length by your Reference Committee and numerous

members of the delegate body. It is your Reference Committee's recommendation that you give this ad hoc committee approval to proceed with search and feasibility studies with regard to land purchase and possible change of Association headquarters to a location more economically and geographically appropriate.

HOUSE OF DELEGATES ACTION—An amendment from the floor was offered to change the third sentence of the Reference Committee recommendation to read as follows: "It is your Reference Committee's recommendation that this ad hoc committee be reappointed to proceed with search and feasibility studies with regard to land purchase and possible change of Association headquarters to a location more economically and geographically appropriate." The House then adopted the report of the Ad Hoc Committee on Building and Land as amended.

WOMEN'S AUXILIARY ANNUAL REPORT

Mrs. John G. Bates, President

The 1973-74 theme for the Woman's Auxiliary to the Medical Association of Georgia has been "Projecting Our Image." County auxiliaries have projected into their own communities, reviewed their needs, and developed plans for meeting these needs.

We are indeed grateful to Braswell E. Collins, M.D., chairman of the Advisory Committee and to all the members of this committee for their support and guidance. A special "thank you" goes to the entire staff of the Medical Association of Georgia for their assistance and cooperation.

The Woman's Auxiliary to the Medical Association of Georgia is composed of 38 component auxiliaries with a membership of 2,457. The membership committee needs your help and cooperation to be able to reach those doctors' wives who are not currently members of the Auxiliary.

Pursuant to receiving the responsibility of the Allied Medical Careers Clubs in Georgia, the Health Manpower Committee has functioned very effectively. A part-time secretary is now employed to handle the paper work and answer correspondence regarding the clubs. The Allied Medical Careers office is located in the Auxiliary room at MAG headquarters. The state AMCC Convention was well-planned and proved to be very rewarding.

State Auxiliary officers and members of county auxiliaries have participated in the various conferences conducted by the AMA Auxiliary.

Contributions to the William R. Dancy, M.D. Student Loan Fund have totaled approximately $7,800. Four loans were made in 1973-74 and the Loan Fund is now worth $49,628.02.

AMA-ERF contributions to medical schools and for the Loan Guarantee Fund have amounted to approximately $11,000 with many fund-raising events not yet reported.

Emphasis has been placed on providing health education and helping to improve the quality of life for all. County auxiliaries have presented programs and directed activities in the areas of Health Education and Health Services. Special emphasis was placed on being informed about current legislation. Members have been urged to join their husbands and become members of GaMPAC.

Concern for others was shown through Nutrition Conferences and Safety programs and projects. To project the image of caring, auxiliary members assisted in areas of mental health, international health, aging and homebound—with a special emphasis on children and youth.

Through the many facets of Auxiliary work we have sought to "Project the Image of Caring" into each city and community in Georgia. It is with much pride and humility that we have sought to fill a need. We urge your continued support. If you need assistance in your medical community, call on your local auxiliary.

RECOMMENDATIONS

The Woman's Auxiliary to the Medical Association of Georgia recommends that:

1. Auxiliary Constitution and Bylaws be printed in the Auxiliary Directory.
2. County medical societies without an auxiliary, encourage their wives to organize county auxiliaries.

REFERENCE COMMITTEE RECOMMENDATION—Your Reference Committee accepts with appreciation and commendation the report of the Woman's Auxiliary to the Medical Association of Georgia. Your Reference Committee approves the inclusion of the Constitution and Bylaws of the Auxiliary in the Auxiliary Directory and notes that this expenditure is budgeted for the ensuing year.

HOUSE OF DELEGATES ACTION—Adopted the report of the Woman's Auxiliary.

Highlights of Council

May 9, 1974

Travel Insurance: Announced the upgrading of death benefits to $100,000 for members while traveling on Association business.

CME in Cancer: Approved the submission of a contract proposal for the study, evaluation and promotion of continuing medical education programs in cancer.

Medical Discipline: Agreed to establish a group of physicians from around the state in various specialties to be called upon by the Board of Medical Examiners to investigate complaints against physicians.

Appointments: Ad Hoc Committee on Transfusions and Transplantation—Frank Matthews, M.D., Decatur as chairman, Robert Vaughan, M.D. of Columbus, Spencer Brewer, M.D. of Atlanta, H. C. Hortman, M.D. of Rome, Robert W. Oliver, Jr., M.D. of Dublin, Menard Ihnen, M.D. of Augusta and Lil P. James, M.D. of Macon.

May 12, 1974

Appointment: MAG Executive Director for 1974-1975—James M. Moffett.

MAG Final General Session

1974 Annual Session Business Meeting Sunday, May 12, 1974

Chairman Blair expressed his appreciation to the members of the Reference Committee for their time and effort and moved that the Reference Committee report be adopted as a whole as amended. This motion was duly seconded and approved.

Election Results

Speaker Rogers then called on Henry Foster, M.D., chairman of the Tellers Committee to announce the results of the election for the office of Second Vice President and the office of Vice Speaker of the House of Delegates. Dr. Foster announced the election results as follows:

Second Vice President—W. Daniel Jordan, M.D., Atlanta. (H. Hilt Hammett, M.D. moved on behalf of Joseph M. Almand, M.D. that the election of Dr. Jordan be made unanimous.) A round of applause indicated concurrence by the House.

Vice Speaker—Ronald F. Galloway, M.D., Augusta.

The Speaker called for unfinished business and there was none. He asked for new business and none was reported.

Speaker Rogers thanked all members of the Reference Committees for the diligent work and thanked all members of the House for their close attention to the work of the House and likewise extended his thanks to the headquarters staff for their assistance in helping with the work of the House. He called for a motion to adjourn the Second Session of the MAG House of Delegates and on motion made and seconded he declared the final session of the House of Delegates adjourned (1:35 p.m.) and then turned the meeting back to President C. E. Bohler for the installation of officers.



Bound volumes of the *Journal* printed during his term of office are presented to outgoing President C. Emory Bohler by his successor J. Rhodes Haverty.

President C. E. Bohler convened the Final Session of the 1974 Annual Session Business Meeting of the Medical Association of Georgia and expressed his appreciation to Drs. Harrison Rogers and L. C. Buchanan for their efficient handling of the business of the House of Delegates.

Installation of Officers

Dr. Bohler asked the incoming president, the officers, the AMA delegates and alternates, councilors and vice councilors, speaker and vice speaker to assemble in front of the speaker's platform for the administering of the oath of office and the installation of officers as follows:

President—J. Rhodes Haverty, Atlanta (1975)
President-Elect—David A. Wells, Dalton (1975)
First Vice President—Luther M. Thomas, Jr., Augusta (1975)
Second Vice President—W. Daniel Jordan, Atlanta (1975)
Speaker of the House—L. C. Buchanan, Decatur (1977)
Vice Speaker of the House—Ronald F. Galloway, Augusta (1977)
Sixth District Councilor—James M. Skinner, Griffin (1977)
Sixth District Vice Councilor—Norman P. Gardner, Thomaston (1977)

Seventh District Councilor—Don Schmidt, Cedartown (1977)
Seventh District Vice Councilor—Richard A. Griffin, Cartersville (1977)
Eighth District Councilor—Robert E. Perry, Jr., Brunswick (1977)
Eighth District Vice Councilor—Joe C. Stubbs, Valdosta (1977)
Medical Association of Atlanta Councilor—John T. Godwin (1977)
Medical Association of Atlanta Vice Councilor—J. Norman Berry, Sandy Springs (1977)
Muscogee County Medical Society Councilor—Jack A. Raines, Columbus (1977)
Muscogee County Medical Society Vice Councilor—Louis A. Hazouri, Columbus (1977)
AMA Delegate—Harrison L. Rogers, Jr., Atlanta (1976)
AMA Delegate—J. Daniel Bateman, Albany (1976)
AMA Alternate Delegate—C. E. Bohler, Brooklet (1976)
AMA Alternate Delegate—F. W. Dowda, Atlanta (1976)

Dr. Bohler administered the oath of office to the assembled new officers of MAG and declared each of the officers duly installed. Dr. Bohler turned the gavel of leadership over to incoming President J. Rhodes Haverty who expressed his appreciation to those present for the honor of being selected President for the 1974-75 year. Dr. Haverty then presented to Dr. Bohler the President's Key and bound volume containing issues of the *Journal of the Medical Association of Georgia* published during Dr. Bohler's term as President.

President Haverty announced that the new MAG Council and Executive Committee would hold their organizational meeting immediately and entertained a motion for adjournment *sine die* of the 120th Annual Session. The Final General Session adjourned at 1:45 p.m.

Official Attendance at the 120th Annual Session was:

144	**Delegates**
39	**Alternate Delegates**
132	**Members**
242	**Woman's Auxiliary**
28	**Guests**
585	**TOTAL ATTENDANCE**

Highlights of Executive Committee of Council

May 9, 1974

HMO: Received report on HMOs, with respect to the law in Georgia, new federal legislation and an open panel "foundation" type of HMOs.

Foreign Medical Graduates: Heard from a member representing the Cobb County foreign medical graduates requesting further MAG support in stopping the Board of Medical Examiners in its decision to require the use of the foreign medical graduates' degree rather than M.D.

Professional Liability Insurance: Received report on new rates for 1974-1975:

	$100/300	*$1 million*	*$5 million*
Class I	$ 285	$142	$213
Class II	495	195	293
Class III	1079	370	555
Class IV	1348	444	666
Class V	1530	494	741

PSRO Repeal: Reviewed recent activities: Repeal Rally in Atlanta April 7, Cookbook Medicine brochure, bumper stickers and the development of a speakers bureau.

EMCRO: Reviewed activities and recent submission of grant and contract proposals for "outcome" studies, statewide Cancer Registry, long term care data evaluation.

GMCF: Received report on activities—current efforts on development of CHEC, peer review contracts with private insurors. Appointed Richard A. Griffin, III, M.D., of Cartersville as alternate director for the 7th District.

Emergency Medical Services Seminar: Approved sponsorship of a Seminar in the fall 1974 on the management of medical and surgical emergencies.

May 12, 1974

Elections and Appointments: Chairman of Council—Fleming L. Jolley, M.D., Atlanta; Vice Chairman—Robert E. Perry, Jr., M.D., Brunswick. Finance Committee: F. G. Eldridge, M.D., Valdosta, chairman; F. William Dowda, M.D., Atlanta and Remer Y. Clark, M.D., Marietta.

David Allen Wells
MAG President-Elect

DAVID ALLEN WELLS, a family practitioner from Dalton, was installed as President-Elect of the Medical Association of Georgia at the Association's 1974 Annual Session Business Meeting May 10-12.

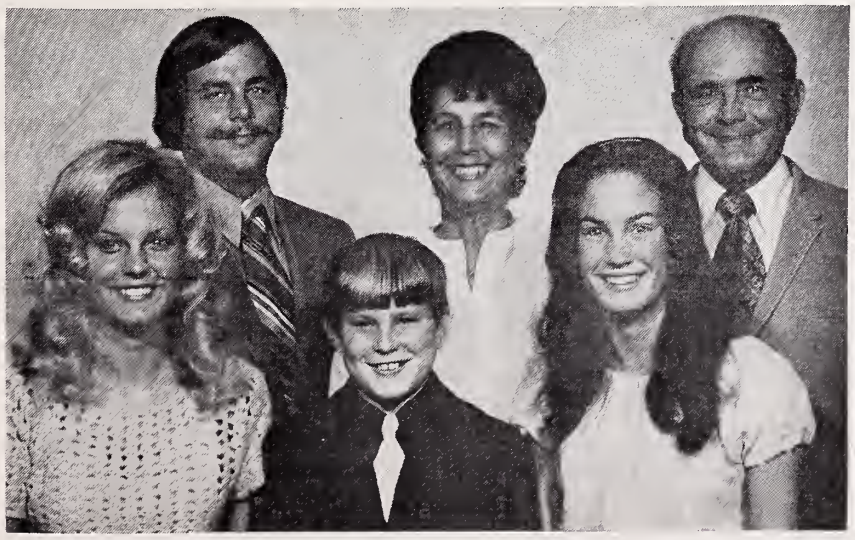
Dr. Wells, born in Hapeville in 1925, was graduated from the Medical College of Georgia in 1949, interned at the U.S. Navy Hospital in Portsmouth, Va., spent two years on active duty in the U.S. Navy and then completed his residency at the Macon Hospital in Macon from 1952 to 1954. He has practiced in Dalton since 1954 and is a Diplomate of the American Board of Family Physicians.

A member of the First United Methodist Church of Dalton, Dr. Wells has been active and outstanding as a civic leader. He has served as chairman of the Dalton Chamber of Commerce, and in this capacity was chairman of the Education Committee at the time Dalton Junior College was established. In addition, he has served as chairman of directors of the Dalton Junior College Foundation and currently is chairman of the Whitfield County Board of Health. Dr. Wells is a booster of the Dalton High School football team and has served as team physician since 1954. He is a member of the Dalton Lions Club. In recognition of his many civic activities, Dr. Wells was presented the Man of the Year in Dalton Award in 1972.

The President-Elect has been valued as a friend and as a leader by his colleagues, serving as an officer in the local and district medical organizations as well as the Medical Association of Georgia.

Dr. and Mrs. Wells, the former Mary Elizabeth Brantly, have four children, David Jr., Carol, Mary Beth and John.

J. Sherwood Jones, M.D.
1209 Memorial Drive
Dalton, Georgia 30720



The President-Elect's family includes (front row, L-R) Carol, John and Mary Beth; (back, L-R) David Jr., Mrs. Wells and Dr. Wells.

Highlights of the 1974 MAG Annual Session

THE 1974 ANNUAL SESSION BUSINESS MEETING of the Medical Association of Georgia was held in Savannah, May 10-12. The meeting brought 585 to the port city to conduct the Association's business.

The session took on a different look this year since there were no athletic events, scientific sessions or commercial exhibits. Participants at a GaMPAC Brunch heard addresses by Congressman Robert H. Michel (R-Ill.) and Rex E. Kenyon, M.D., a member of the AMPAC board of trustees. A full account of each report and resolution in addition to the various Reference Committee recommendations and subsequent House action can be found elsewhere in this Journal.

Awards

Ollie O. McGahee, M.D. of Jesup was named the Family Physician of the Year; the Distinguished Service Award was presented to John L. Elliott, M.D. of Savannah; the Civic Endeavor Award was given to Robert L. Donner, M.D.. of Macon.

Officers

J. Rhodes Haverty, M.D. of Atlanta was installed as president, C. Emory Bohler, M.D. of Brooklet as immediate past president and David A. Wells, M.D. of Dalton was elected as president-elect. Other officers either installed or elected were: Luther M. Thomas, M.D., Augusta, as first vice president; W. Daniel Jordan, M.D. of Atlanta as second vice president; L. C. Buchanan, M.D. of Decatur as speaker; Ronald F. Galloway, M.D. of Augusta as vice speaker; Harrison L. Rogers, M.D. of Atlanta as AMA delegate; C. Emory Bohler, M.D., Brooklet, AMA alternate delegate; J. Dan Bateman, M.D., Albany, as AMA delegate and F. William Dowda, M.D. of Atlanta as AMA alternate delegate.

Access to Health Care

The House approved the thought that the public should be made aware that not every town in the state can support or really needs a physician. It was also noted that MAG should assist communities in appropriate ways to evaluate their health care needs and the solutions to their problems.

It was also accepted that MAG should work in an effective manner to promote the Family Physician by assistance in the establishment of family practice residencies and preceptorships and other appropriate methods.

Communications Committee

The House adopted the proposal that MAG should continue an aggressive communications program geared to informing the profession as well as the public in general and the news media in particular.

Constitution and Bylaws

The House reviewed requested Constitutional changes to permit representatives of the Interspecialty Council to have voting membership in the House of Delegates. This recommendation was rejected by the House. It was noted that Bylaws changes had already occurred to allow the chairman of the

Council to sit on the MAG Council. It was voted to remove this section from the Bylaws.

It was also approved to allow a physician transferring from another state medical association to be exempt from paying current dues provided that he has paid all dues to the state association from which he came.

Organization and Functions

The House approved new purposes for the Association as recommended by this committee. Among those stated were the maintenance of the physician-patient relationship, the promotion of quality medical care at reasonable cost and to seek provision of access of medical care to all Georgians regardless of their financial situation.

GaMPAC

A resolution was adopted to urge every member of the House in particular and the Association in general to become active dues paying members of the PAC movement. Also that our delegates to the AMA should be instructed to introduce a similar resolution to that body.

President Elect's Speech

The Constitution and By-laws Committee was instructed to develop appropriate language to allow the MAG Finance Committee to become a committee of the House rather than the Council.

It was also approved that MAG should develop a series of policy statements on various issues that, after review, would become official statements for public consumption.

Education Committee

The House endorsed the addition of an educational coordinator for the Association to coordinate all educational and scientific functions. The reference committee added that this program be adopted for a two year period with a report to be made to the House in 1976.

It was further recommended that MAG engage in a study of the practices of physicians in the state so data could be gathered relative to practice trends, areas of coverage of various practices and the maldistribution of doctors in the state. It was also mandated that the Association seek out appropriate funding for the study.

A further recommendation adopted by the House was that the president should refer to the appropriate committee the study of relicensure and recertification in the U.S. and its application for the state of Georgia in the future. This study is to be completed and a report prepared by the 1975 Annual Session.

EMCRO

The report of this committee called for a statewide tumor registry program to be under the EMCRO. By action of the House, this responsibility has been referred to the MAG Cancer Committee which is to look at the prospects for such a registry and report back to the House in 1975.

Immediate Past President

In this report was a recommendation for the hiring of a full time medical director for the Association. Upon suggestion of the reference committee, the House rejected this.

PSRO

After some eight hours of reference committee debate on the PSRO issue followed by over two hours of House floor discussion, the House voted to take

the direction of unqualified repeal of the PSRO statute of P.L. 92-603. Further commenting, the reference committee stated that PSRO provided onerous roadblocks to the provision of quality health care and holds no hope of reducing medical costs but would escalate them.

MAG is to continue to work vigorously for the repeal of this law as well as maintaining our PSRO educational links with the citizens of Georgia and expanding our liaison with other state medical associations to show unity of purpose.

The MAG Executive Committee had previously approved the submission of a PSRO planning contract application predicated on concurrence and approval of the House of Delegates. After deliberation, it was determined to request the removal of this application for consideration.

Committee on Annual Sessions

It was adopted that the Association should continue to present a top-notch scientific session in the fall of 1975 if it is deemed possible by the coordinating committee.

Committee on Physician-Lawyer Liaison

The House adopted a stand that each county medical society should consider the arrangement of a joint meeting with the local bar association at regular intervals to address problems of mutual interest to the two groups.

Committee on Public Health

This committee will address specifically the problem of VD education in Georgia. It was recommended that each physician should express himself in a manner chosen by the individual as to the moral breakdown which has resulted in the increased incidence of VD.

Finance Committee Report

The report of this committee was accepted, noting that the total MAG budget for FY 74-75 would show a 7.17 per cent increase over the previous year. It was also noted that current expenses do not exceed income.

Committee on Building and Land Study

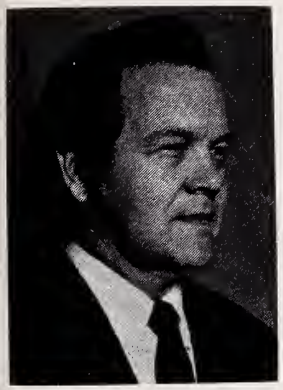
It was recommended that this committee be reappointed and proceed with search and feasibility studies with regard to land purchase and possible change of Association headquarters to a location more economically and geographically appropriate.

Future Meeting Sites

1975 (April 17-20) Atlanta (Fairmont)
1976 (April 8-10) Jekyll Island (Aquarama)
1977 (April 22-25) Macon (Macon Hilton)
1978 (April 20-22) Augusta (Executive House)

president's letter

Marvelously Strange



THERE'S GOT TO BE SOMETHING STRANGE about people who work for physicians! There's got to be something peculiar—almost masochistic—about people who work hard for long hours; who give up much of their own free time; who are obviously dedicated to their work and their employers; and who find deep satisfaction and meaning in their lives, not always measured in the coin of the realm.

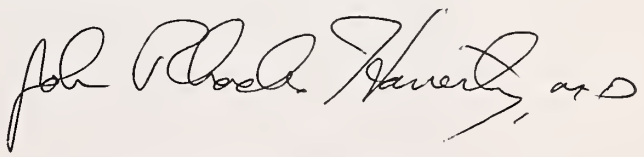
I have just concluded three days of meetings in Chicago and Atlanta, involving staff people representing three different organizations: the American Medical Association, the American Academy of Pediatrics, and the Georgia Medical Care Foundation. In thinking about these meetings, and the ease and usefulness with which they were conducted because of staff organization and expertise, I remembered our own fine MAG staff, so close to me for so many years, and realized how much I have taken them and their excellence for granted. These people, multiplied throughout the nation, in all manner of physician concerns, perform with amazing skill, interests, and perseverance far beyond the kinds of assistance found in fields other than medicine.

My fond recollection of my "help" in my pediatric office, and the comments I hear from my still-practicing friends and their office personnel immediately recall to me that this phenomenon is not limited to the various aspects of "organized medicine." Physicians have a fiercely loyal, protective, and affectionate group of employees wherever they find themselves.

I wonder why. Perhaps the field of medicine is an arena that attracts such dedication, or brings it out. Perhaps physicians themselves are of such clay that produces this affection. Probably these two are related in that medicine attracts, holds, and rededicates individuals who are fortunate enough to be caught up in its web.

Some special aura surrounds, nurtures, and satisfies those who deal in services to others, and this seems to rub off on all who have a part in this serving. The spending of one's talents and one's time for unselfish but valuable service to others has to be some of the most rewarding experiences life offers. And this is what *all* of us involved in *every* aspect of the practice of medicine participate in. It's too bad everyone can't appreciate this sense of achievement.

Like I said, there's got to be something strange about people who work for physicians. Something marvelously strange!



John Rhodes Haverty, M.D.
President, Medical Association of Georgia

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heart page

The Use of Psychotropic Agents in Heart Disease

MARTIN L. THRONE, M.D., *Atlanta**

MANY OF THE DRUGS used in the treatment of nervous and mental disorders have severe cardiovascular side effects which limit their usefulness. In addition, significant drug interactions involving these agents have been described, and warrant close attention. This paper will attempt to cover some of these.

Amphetamines

The sympathomimetic activity of the amphetamines obviously makes their use in patients with ischemic heart disease potentially dangerous.[1-3] Since the use of these drugs is limited at present, further discussion is unwarranted.

Phenothiazines

The phenothiazine group of tranquilizers has a complex action on the cardiovascular system, via direct effects on the heart and blood vessels, as well as indirect effects on central nervous system and autonomic reflexes.[4] Numerous case reports of sudden deaths, secondary to cardiac dysrhythmias, in patients treated over long terms with these agents have been reported. They produce orthostatic hypotension, often leading to syncope, secondary to inhibition of centrally mediated pressor reflexes, as well as to peripheral alpha-adrenergic blockade. In addition, they have a direct depressant action on the heart, leading to negative ionotropic response. Their vasodilating action occurs through effects both on the autonomic nervous system, and direct action on the arteriolar bed. Reflex tachycardia occurs secondary to the hypotension produced by lowered peripheral vascular resistance, as well as a slight atropine-like effect.[5-7]

ECG changes, consisting of prolongation of the Q-Tc interval, blunting of the T waves, and changes mimicking acute myocardial infarction have been described. Despite their apparent Quinidine-like anti-arrhythmic action, the phenothiazines have been reported to produce supraventricular, as well as ventricular tachyarrythmias.

Although the exact mode of action is unknown, several mechanisms have been postulated to account for the cardiac toxicity produced by the phenothiazines, including: 1. Increase in circulating plasma catecholamines. The high catecholamine levels in blood and urine (sometimes as high as those found in patients with pheochromocytomas) have been attributed to inhibition of tissue reuptake of norepinephrine through competitive binding on the cell membrane. These higher levels occur even in patients who are hypotensive on the drug; 2. A toxic cardiomyopathy; 3. Deposition of acid mucopolysaccharide material in myocardial tissue, particularly in subendocardial arterioles; 4. Quinidine-like activity producing a prolongation of the Q-Tc interval.

The action of the MAOI's in causing fatal hypertensive crises in patients in-

* Suite F, 3648 Chamblee-Tucker Road N.E., Atlanta, Ga. 30341. Prepared at the request of the Committee on Physician Education of the Georgia Heart Association.

gesting certain tyramine rich foods (some cheeses, Chianti, etc.), is well known. Hepatic MAO inactivates any tyramine absorbed in the diet. In patients treated with MAOI's, the monamine oxidase enzyme is permanently inhibited. Thus, tyramine which is absorbed by the gut, is not metabolized by the liver, thereby reaching the adrenergic neuron in large quantities, causing the release of large quantities of norepinephrine, which produces the marked pressor effect.[8]

Tricyclic Antidepressants

The patient on tricyclic antidepressants can manifest cardiovascular toxicity in a number of ways: severe headache, failure to respond to a previously well controlled antihypertensive regime, cardiac arrhythmias, cerebral hemorrhage, hypertensive crises, or sudden death.

The tricyclic antidepressants have at various times been reported to produce: orthostatic hypotension, ECG changes (ST segment changes, T wave inversion or flattening, prolongation of the Q-Tc interval), PVC's, atrial and ventricular arrhythmias, acute myocardial infarction, congestive heart failure, and cardiac arrest.[9-11] Most of the information concerning the cardiotoxicity of these agents has been based on isolated case reports without sound statistical support. One psychiatric hospital-based drug surveillance study reported six cases of sudden death in cardiac patients on amitriptyline, as opposed to no deaths in a matched control group with similar heart problems not on amitriptyline.[11] The tricyclics have the ability to antagonize the antihypertensive action of guanethidine (Ismelin). Thus, when a tricyclic is given to a patient whose blood pressure is well controlled with guanethidine, the blood pressure will increase. This effect can be insidious, in that a patient whose blood pressure was previously well controlled on guanethidine now requires increasing doses of the drug to maintain control.[8] That this response is not due to a simple pressor effect of the two drugs in combination is borne out by the observation that when guanethidine is administered to a patient on a tricyclic, there is no increase in blood pressure.[12] The mechanism of drug interaction in this case is well worked out: the tricyclics block the norepinephrine pump in the adrenergic neuron membrane, thereby preventing the uptake of guanethidine to its active site within the neuron.[13] Methyldopa (Aldomet) does not enter the neuron via the norepinephrine pump, therefore, its antihypertensive activity is not affected by the concomitant administration of a tricyclic compound.

In summary, because of the widespread cardiovascular effects of psychotropic agents, it is best to avoid their use in patients with known cardiac disease. If depression is severe, it is probably best to treat with small doses of drugs with frequent ECG monitoring, and careful observation for signs of congestive heart failure. ■

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More (or less) on HMOs

J. WINSTON HUFF, *Atlanta**

THE NEW FEDERAL HEALTH MAINTENANCE Organization Act of 1973† (Public Law 93-222) has caused much discussion. At the end of April I attended a seminar in Boston on the legal aspects of HMOs to find out what this animal looks like and what it is all about. Some of the information might be of interest to Georgia physicians.

Many Types of HMOs

The new federal law does not provide for the establishment of HMOs. This law only says what must be done in the way of organization, benefits offered, etc., in order for an HMO to obtain federal grants and loans.

It is estimated that there are 100 to 150 HMOs of one kind or another now operating in the United States. They take many forms. One HEW official at the Boston meeting predicted that not a single one of them is now set up in a way to qualify for federal money under the new law. Some of the types of HMOs discussed were:

Consumer: The HMO incorporates and enrolls prepaid subscribers from large groups such as unions, government employees, teachers' groups, etc. The HMO owns its hospital and other facilities and does its own marketing and administration. It may directly employ its physicians on a salary basis or contract with a medical group. The risks of health coverage may or may not be reinsured by an insurance company.

Physician Sponsorship: An established medical group contracts directly with its subscribers on a prepaid capitation basis for inpatient and outpatient care. The group may bear all of the risk or may bear the risk up to a set dollar amount with an insurance company bearing the risk above that amount. The group will contract with a hospital for inpatient care.

Hospital Sponsorship: Here the hospital does much the same as the physician group. It may contract with a group of physicians or may employ them directly where permitted by state law. This could, however, affect the hospital's tax free status, as described below.

Insurance Company Sponsorship: The insurance company offers its customers a prepaid HMO option to the usual health indemnity contract. The insurance company contracts with a group of physicians for outpatient services on a per capita basis and also contracts with a hospital for inpatient care. Control of marketing and administration is vested in the insurance company. A speaker from the Aetna Group stated that his company was setting up an HMO plan under

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* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, Atlanta, Ga. 30303.

† For an outline of the provisions of the federal HMO law, see the February 1974 issue of *JMAG*.

which a subsidiary company will own the facilities and operate the HMO for profit.

Foundation Plans: The subscriber here enrolls on a prepaid basis with a medical care foundation. Hospital risk may be borne by the plan or it may be reinsured with an insurance company. Out patient services are provided by member physicians on a fee-for-service basis. Peer review is provided by the foundation. In some foundation plans, the member physician receives only 85 per cent of his fee, the remaining 15 per cent going into a reserve against losses. In other cases the 15 per cent is divided among the physicians after a period of time.

It seemed to me that there are almost as many types of plans as there are HMOs. Some employ closed panel and some open panel physicians. It is evident that the particular plan must be tailored to fit a particular situation and the requirements of state law in that locality.

Feasibility

Many of the speakers felt that an HMO set up to qualify for federal funds under the new law will not be able to sell its plan to the public. It was their judgment that the premium necessary to cover the required services will price this type of HMO plan out of the market. Especially mentioned was the requirement of full preventive health care, the extremely broad range of required services, the necessity to enroll "medically underserved" and the disregard of prior health status. The risks of this type of contract are really unknown and it was felt that the health package will have to be narrowed to put the premium within range of most people.

Also mentioned was employee resistance. In employer-sponsored plans where the employer pays up to a set dollar amount and the employee pays the rest, the higher amount of premium to be paid by the employee may cause market resistance.

An interesting aside is the effect the new law may have on contract bargaining between employers and unions. The law requires that where there is an HMO available, employers who are subject to the minimum wage law and have an average of 25 employees must have an HMO option in any health benefit package. Will (or can) the union choose the HMO alternative for its members? Or does the choice reside in the employee? Where the union contract fringe package includes one set sum for pensions and other benefits in addition to health care, will the union permit a member to opt out for an HMO? If many union members choose the HMO, it could disrupt the entire benefit package. What happens in the case of industry-wide bargaining where a number of large employers are scattered all over the country? Many questions are apparent, but there are at present few answers.

Regulations

Some regulations have been published, but it will probably be several months before the regulations are complete. The problems presented by the new law are complex and difficult because of the manner in which the law was written. One speaker likened the law to the definition of a camel—an animal designed by a committee.

Tax Exempt Status?

It is possible that non-profit HMOs may obtain tax exempt status if organized properly. However, there are several classifications of tax exempt organizations, and it is not likely that HMOs will fall within the "charitable" classification. This means that an HMO will not be able freely to obtain gifts from private foundations; individual contributions to it will not be tax deductible; and the HMO property will be subject to ad valorem tax. If a hospital operates an HMO, then the hospital may lose its exemption as a "charity" and, although still tax exempt, will not have the benefits above described which a charitable organization has.

This is a very difficult area. In the case of HMOs there are no authoritative rulings and things seem generally confused within the Internal Revenue Service.

State Laws

The new federal law overrides state law in four limited areas. However, this by no means disposes of many legal barriers for HMOs, whether they do or do not qualify under the federal law. It is important to keep in mind that this federal supremacy applies only where the HMO is receiving federal funds.

Corporate Practice of Medicine: Georgia law prohibits the employment of physicians by a corporation except in a professional corporation or in medical schools and in teaching institutions. This would rule out direct salaried employment by an HMO in this state. It might be stretched to mean (the courts have not passed on the question) that there can be no contractural relationship between a closed-panel group and an HMO. The Attorney General of California has ruled that an agreement between a proprietary hospital and an M.D.-director of one of its departments constituted the unlawful practice of medicine by the hospital. Would the same be true in the case of an HMO?

Insurance Laws: Is the HMO selling a "service" or is it selling "insurance"? It is my opinion that it sells insurance. Although the new federal law supersedes certain aspects of state insurance law there are many other provisions of state insurance laws not overridden. These would have to be complied with. Further, if an HMO did not want to qualify for federal funds, then it would have to meet all applicable insurance laws. These laws, in my opinion, could deter the establishment of HMOs in Georgia and elsewhere.

Advertising: An HMO generally must advertise for subscribers. Here again, if the HMO qualifies for federal funds, state laws prohibiting advertising by physicians are overriden, although the advertisement cannot identify or tout the physician providers. But where the HMO is not attempting to get federal funds, legal prohibitions against physicians advertising might be brought to bear against HMOs.

Certificate of Need: We have no certificate of need legislation in Georgia, other than for nursing homes. However, where such laws exist, they could be a restrictive influence on the establishment of HMO facilities. ■

Use of the Designation "M.D." by Foreign Medical Graduates

HAL ROACH, JR., *Atlanta**

IN THE RECENT CASE of *Oliver v. Morton,* 361 F.Supp. 1263 (1973) a federal three-judge panel considered the question of the proper construction and application of Ga. Code §84-907.2. That Code section provides as follows:

> "On all licenses issued by the Board after the passage of this section the Board shall enter after the name of the licensee the degree to which the licensee is entitled by reason of his diploma of graduation from a professional school in good standing with the Board."

This litigation was begun by Richard T. Oliver, who was fully licensed to practice medicine in the State of Georgia and held the academic degree of Doctor of

* Deputy Assistant Attorney General, State of Georgia, 132 State Judicial Building, Atlanta, Ga. 30334.

Osteopathy (D.O.). Dr. Oliver alleged that the statute quoted above was discriminatory in various ways. The thrust of his suit was to enjoin the Composite State Board of Medical Examiners from requiring him to use the designation "D.O." after his name, and to compel the Board to allow him to use the designation "M.D."

The three-judge federal panel held that the statute quoted above was basically constitutional since "there are meaningful distinctions between D.O.s and M.D.s." The Court further stated that "[t]he State's requirement that physicians hold themselves out to the public under the professional degree which they have received is . . . a rational requirement. . . ."

Discriminatory Enforcement

However, the Court also held that the statute was being enforced by the Composite State Board of Medical Examiners in a discriminatory manner because numerous foreign trained physicians which the Court found not to possess the degree of M.D. were being allowed nevertheless to use the designation "M.D." Therefore the Court permanently enjoined the Composite State Board of Medical Examiners from refusing to grant Dr. Oliver a license with the designation "M.D." so long as it grants licenses with the designation "M.D." to foreign trained physicians who do not have an M.D. degree. The order went on to say that for the purposes of the injunction, all foreign degrees which translate "directly into English as Medical Doctor, Doctor of Medicine, or degree of Doctor of Medicine" are considered to be M.D. degrees.

Since it is the duty of the Composite State Board of Medical Examiners to enforce a valid statute, the Board began to translate the diplomas, certificates, and degrees of all foreign trained doctors licensed in this state. After the translations were made, all physicians whose degrees were not translated directly into one of the terms set forth above were notified that the designation to be used after their name would have to be altered. There was an immediate reaction on the part of those physicians affected, most of whom claimed, and quite understandably so, that the public would not understand that they were in fact licensed medical practitioners in this state. (The change of the designation after the physician's name has no legal effect upon his right to practice medicine in this state.) Also, many physicians raised questions as to the accuracy of the translations made by the Board.

Inexact Translations

In view of the fact that translation is at best an inexact art, the Board felt that in order to be fair to everyone concerned, an additional effort to translate these degrees properly should be made. Therefore a letter was sent to all physicians affected notifying them that they should continue to use the designation "M.D." until further notice from the Board. At this time experts are aiding the Board in the translation of these degrees, certificates, and diplomas. While the Composite State Board of Medical Examiners wishes to be absolutely fair to everyone concerned in this matter, it is also bound by law to enforce a valid state statute, and to obey the injunction issued by the three-judge federal court. Every effort will be made to comply with all of these responsibilities. It is possible that additional legislation will be offered in the next legislative session; however, the ultimate resolution of this problem is uncertain, and it may be that additional litigation will ensue. ■

I've told this before . . . .

(Ed. note: Memories of college days can last long after June's graduation, especially when influenced by an "exceptional" professor, as in this story by J. G. McDaniel, M.D. of Atlanta. Others wishing to contribute to this feature page should send their writings to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Georgia 30309.)*

A Temperamental Hearing Aid

SEVERAL OF US WERE VISITING a mutual friend in the hospital not too long ago when Dean David Collins of the Cathedral of St. Philip called on the semi-ill individual. For some reason we fell to discussing "little strokes" and he told an interesting story that occurred during his college days at the University of the South in Sewanee, Tennessee.

It seems that there was a beloved and brilliant professor of history there who in his later years had some type of cerebral vascular accident. It was mild in nature and he completely recovered with the exception of an occasional motor aphasia that would last only five to fifteen seconds. The good professor would be lecturing along in his inimitable fashion and abruptly cease speaking. The words would just not come out. As suddenly, the voice would reappear and the lecture would go on without losing its trend.

Students and teachers soon learned to accept this with equanimity, as evidenced by his courses being as popular as ever before.

Then one day a divinity student enrolled. He was partially deaf, but had excellent correction by use of a hearing aid. The poor student did not know about the aphasia. During the first lecture as he was hastily taking notes, the voice stopped, he looked around and noted the rapt attention of his classmates, then he commenced adjusting his hearing aid. Soon he gave a start and hastily readjusted it as the voice came back.

This went on for several lectures, sometimes he would take out his little gadget, shake it, look at it and frown, reinsert it and it would work fine until maybe the next lecture.

At the close of about the third session, several of the students "wised him up," especially after he had threatened to throw his temperamental hearing device in the creek. He looked a little downcast after the revelation and all present hastily apologized for not having told him about it sooner.

He reassured them immediately, however, that he was not sore with anyone, in fact, he could see the humorous side of it. The only thing that galled him was the fact that he was going to have to apologize to the hearing aid repair man. It seems this artisan had told him several times, in no uncertain terms, that his instrument worked perfectly. He further suggested on the last visit, that if he had more trouble to see a psychiatrist and not him. This brought on words, some that did not fit well in the vocabulary of a divinity student and some that did not fall gently on his hearing aid.

J. G. McDaniel, M.D.

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SOCIETIES

The annual meeting of the **First District Medical Society,** which included both scientific and social activities, was held April 24 in Statesboro. Eugene Pope Bargeron of Savannah has assumed the office of president for this district society. Leon E. Curry of Metter is vice-president and Maurice Whiddon, Savannah, is treasurer.

New officers of the **Second District Medical Society,** elected April 20 in Albany, include Frank Gibson, Bainbridge, as president and Laurence T. Crimmins of Albany as secretary-treasurer.

PERSONALS

First District

Savannah physicians **Robert DiBenedetto** and **Paul F. Jurgensen** have been inducted as Fellows of the American College of Physicians.

Leon Curry of Metter discussed the problems of the hyperactive child before the Parents' Group of Learning Disabled and Hyperactive Children at an April meeting in Waycross. The speech was videotaped to make it available to other groups.

Third District

John S. Rogers of Buena Vista was selected by the Schering Corporation to attend a nationwide seminar on Gram Negative Infections presented at the Ochsner Clinic in New Orleans, La.

Fourth District

James A. Woodall of Thomaston was honored on the occasion of retirement after 37 years of practice by the Auxiliary to the Upson County Medical Society on Doctors Day at the end of March.

Fifth District

Thomas E. Whitesides, Jr., professor of surgery at Emory University was chosen as the annual Visiting Professor of Surgery at Columbia University Medical School and Columbia Presbyterian Hospital in New York. During his week at the University in April, Dr. Whitesides delivered a series of lectures and demonstrated specialized surgical techniques.

Serving as co-chairman of the Atlanta Israel Bond Campaign for 1974 is Atlanta physician **Lawrence E. Cooper.**

Sixth District

Eighty-five-year-old **R. H. McDonald,** or "Dr. Mac" was the subject of a feature story in the April 4 edition of the *Newnan Times-Herald.* Dr. Mac is still active and served as the Coweta County doctor from 1930 to 1971.

Seventh District

Lewis H. Lipsius, formerly of Atlanta, has joined the Harbin Clinic in Rome for practice in the field of psychiatry. He is a graduate of Emory University School of Medicine.

Ninth District

W. D. Stribling of the Northeast Georgia Diagnostic Clinic and chairman of the Gainesville-Hall County Drug Abuse Steering Committee, addressed a seminar on the subject of alcohol and drug abuse at Brenau College April 25.

Duluth physician **Miles H. Mason, Jr.** has been appointed to the Board of Counselors for Oxford College of Emory University.

DEATHS

Wallace Lee Bazemore

Macon urologist Wallace Lee Bazemore died April 21, 1974 at the age of 77.

Dr. Bazemore was born and educated in Bibb County and received his M.D. degree from Emory University. He served as president of the Bibb County Medical Society in 1937, was a Diplomate of the American Urological Association and life member of the American College of Surgeons.

During World War I, Dr. Bazemore served in the U.S. Navy. He was a member of the Macon Elks Club, Pi Kappa Phi fraternity and the First Presbyterian Church of Macon.

Survivors include his widow, Mrs. Jessie Rose Duncan Bazemore of Macon; son, Dr. W. Duncan Bazemore of Trinidad, California; half-brother, Fred Flowers, Sr. of Hartwell; grandson, cousin and nephew.

James K. Fancher

James K. Fancher, 81, of Atlanta, died April 24.

Well known for his benevolent work, Dr. Fancher was co-founder and president of the Medical Benevolence Foundation and served on the medical staff of the Anneewakee Foundation for Boys. He was an elder of the First Presbyterian Church of Atlanta, a Shriner and Scottish Rite Mason.

Dr. Fancher formerly served as chief of staff for Piedmont Hospital, was director of Good Samaritan Clinic and had served on the faculties of Emory University School of Medicine and the Atlanta College of Pharmacy. He was a member of the American College of Physicians, was vice president of the Endocrine Soci-

ety and a member of the executive board of the American Therapeutic Society.

Survivors include his widow, Mrs. Margaret Van Devanter Fancher; son, J. K. Fancher, Jr. of Atlanta; and his daughter, Mrs. Erwin Grimes of Houston, Texas.

Henry Ray Fenn

Henry Ray Fenn, 55, who for 20 years had served as the first and only medical examiner of Sumter and Lee counties, died April 1, 1974 at the Americus and Sumter County Hospital after a brief illness.

Dr. Fenn was born in Cordele, earned his M.D. degree from the Medical College of Georgia, and served his residency in surgery and orthopedic medicine at the University Hospital.

A 28-year resident of Americus, Dr. Fenn was vice president of the Flint River Sports Shooting Association, the Georgia Sheriffs Association and the First United Methodist Church.

He is survived by his widow, Mrs. Jane Anderson Fenn; daughter, Miss Theresa Fenn; son, Christopher Fenn, all of Americus; and sister, Mrs. Jane Teate of Dooly County; nieces and nephews.

Oscar Emerson Ham

O. Emerson Ham, 60, of Savannah, died April 28, 1974 following a brief illness.

Dr. Ham was born in Atlanta and attended Emory University School of Medicine before moving to Savannah with the U.S. Public Health Service in 1940. He later entered private practice in pediatrics. He was past commodore of the U.S. Coast Guard Auxiliary in Savannah.

Survivors include his widow, Mrs. Ruth McCurry Ham; three sons, Dr. Oscar Emerson Ham, Jr., Charles W. and William L. Ham, all of Savannah; two sisters, Mrs. Robert Davis of Westwood, Mass. and Mrs. Bruce Betts of Charlotte, N.C.; four grandchildren.



In a brief ceremony April 10, LaMar McGinnis, M.D. (L), chairman of the Subcommittee on Accreditation of MAG Education Committee presents a certificate of accreditation to Piedmont Hospital. Accepting the certificate, which indicates that Piedmont has met the standards of AMA for its continuing education program, are Charles F. Stone, Jr., M.D., chairman of the board of trustees at Piedmont and Mark E. Silverman, M.D., Emory/Piedmont professor of medicine.

The Month in Washington

Triggered by the surprise introduction of a Kennedy-Mills proposal for national health insurance and a major effort by the Nixon Administration to get its own bill through this year, the Congress has again started a hot and heavy debate on the complex issues involved.

Appearing before the House Ways and Means Committee, Russell B. Roth, M.D., president of the American Medical Association, warned that most of the congressional push for national health insurance (NHI) is based on the false premise that there is a health care crisis.

"The fact is," Dr. Roth told the Committee, "more people are receiving more and better medical care from more and better trained physicians in more and better equipped facilities than ever before in history. These are not elements of crisis. The fact also is that the public, as its opinion has been judged in various polls, does not perceive medical service to be a major problem area.

Polls Disprove Crisis

"No doubt the Committee recalls a recent Louis Harris poll, commissioned by a Senate subcommittee, which indicated that whereas 64 per cent of the sample identified inflation as our nation's most serious problem, health care rated 15th, or next to last on the list, with only 3 per cent of the respondents putting emphasis on this. Inasmuch as any of the proposals for extensions of federal subsidies for medical service are inevitably inflationary to some degree, one wonders about the advisability of further aggravating this most serious problem in order to attack a problem of much lesser magnitude.

"Poll after poll confirms that people are generally satisfied with the type of health care they personally receive. This satisfaction relies on wide experience, for some 2.5 million people a day see a physician. A 1971 University of Chicago study, based on a nationwide sample, found 84 per cent of the people satisfied, only 10 per cent dissatisfied. Just last month a survey commissioned by the *Washington Post* uncovered a virtually identical pattern in this area. According to Mr. Jay Mathews' story, six of every seven local residents are at least 'pretty satisfied' with their medical care. Only one person in ten expressed any measure of discontent. It would be an interesting exercise to see if you could find another issue or subject these days upon which Americans would voice 85 or 90 per cent agreement.

"Reflected in the results of the polls is a record of at least 10 years of substantial progress. During this period the number of American medical schools and the number of physicians available to the American public have been increasing. Physician numbers will continue to increase at a pace which exceeds the general population growth rate."

Speaking strongly in support of the AMA sponsored Medicredit bill for NHI, Dr. Roth urged the Committee to follow the guiding principles developed by the AMA in its proposed legislation.

"We are convinced," Dr. Roth said, "that financial barriers to medical services are as real for middle income persons as for the poor—that there is great virtue in attention to ability to pay deductible and coinsurance amounts—and that our graded tax-credit approach is a superior feature in adjusting subsidies to needs.

Lashing out at the Kennedy-Mills NHI proposal, Dr. Roth said, "It is one thing to mandate the purchase of private insurance by employers. It is something quite different to institute increased payroll taxes, destroy the future of private insurance and shift a well-regarded private function into a federal agency.

Problems With Kennedy-Mills Bill

The financing envisioned in the Kennedy-Mills proposal gives us several problems:

"It creates a massive 4 per cent increase in the Social Security tax. Wage earners will not be deluded by the fact that 3 per cent is to be paid by employers and 1 per cent by employees. The Public is sophisticated enough to know that there is no free ride in this respect and the source of the funds to pay for such federal programs is from their compensation.

"We would point out further that under Social Security taxes, he who earns $20,000 a year pays the same as the person who earns 90 or 100 thousand. In our view, it would be more equitable for those who make more to pay more. We would prefer the sort of consistent sliding scale approach that is embodied in the Medicredit bill. Finally, we would seriously question the proposition that by eliminating the profit factor Social Security handling of health insurance finances will bring economies and efficiencies.

"The track record of government—our own and others as well—provides scant historical evidence that its capacity to manage surpasses private management in terms of either efficiency or economy.

"Administrative control derives in large part from financing mechanisms, and, since we advise strongly against control of a new program by the Social Security Administration, we would avoid Social Security financing.

"There can be no justification for the establishment of a vast and expensive new corps of clerks and bureaucrats dedicated to the task of complicating what should be a relatively simple program for placing in the hands of the eligible beneficiary a policy of insurance or a contract for service tailored to his needs."

Weinberger on NHI

The day before the AMA testimony before the Ways and Means Committee, Health, Education, and Welfare Secretary Caspar Weinberger told committee members that the Administration is dead serious about pushing for enactment of a NHI program this year.

Secretary Weinberger came down hard on the Kennedy-Mills proposal that would move toward the federalization of the nation's health care.

Discussing the "fundamental differences" between the so-called compromise plan sponsored by Kennedy and Mills, and the Administration's Comprehensive Health Insurance Plan (CHIP), Weinberger declared:

"I would be less than candid if I did not stress how strongly we are committed to the basic principles of the CHIP proposal."

The Secretary told the crowded hearing room that "the national climate has never been more favorable for the development of a sound concensus on a national program of health insurance. . . . I am here to urge—just as strongly as I possibly can, personally and on behalf of the Administration—that this clear chance at solid accomplishment not pass without the nation's action.

"We firmly reject the views of those few who counsel that no action be taken until some vague future time when they believe that their own plan can be enacted. "Such a time will never arrive."

A major reason for prompt action, Weinberger said, is the prospect that "the American people appear to be in for a very rough period indeed as far as health care costs are concerned." Congress' failure to approve continued wage-price controls on health could lead to a $4 billion to $5 billion increase in health care costs next fiscal year and $9 billion the following year, he cautioned.

If this happens, all current cost estimates for various NHI proposals "would be far too low." He said "the Nation desperately needs measures to avoid such a pocketbook disaster."

In devising the CHIP plan, based on mandated employer health insurance plans for employees, Weinberger said the Administration believed "it is imperative to improve, rather than demolish, the present system."

Though the cabinet secretary took swipes at all the major NHI competitors to CHIP, he not surprisingly reserved most of his fire for the Mills-Kennedy compromise. This bill calls for a Social Security NHI financed by a four per cent tax and administered by Social Security as a virtually independent agency.

Mills-Kennedy, according to Weinberger, "would take a major step down the road toward complete federal financing and control of all health care in the United States.

"If that policy approach were to prevail, I feel there would be no turning back."

The financing of health care is too important to the people "to turn over to a federal bureaucracy," he asserted. Noting the complexities of the health system and the relative lack of knowledge of its workings, he said "in these circumstances the dangers of turning financial control of this vital industry over to an enormous new federal bureaucracy are considerable."

Quashing speculation that the Administration might try to reach an accommodation on the Mills-Kennedy approach, Weinberger hammered away at it, making it plain that he regarded the Mills-Kennedy plan as the big danger. He said it would stifle private initiative "under piles of paperwork and federal regulations."

"We believe that the federal role in health financing must be clearly limited, as it is in CHIP. National

health insurance should not be the nationalization of the health system."

The Administration officer said Mills-Kennedy would impose $40 billion of new federal taxes "on top of a tax burden that many Americans already believe is excessive." Furthermore, Weinberger said, "payroll taxes are a much greater burden on the poor than is general revenue financing."

He said the Kennedy-Mills plan would virtually eliminate privately administered health insurance and substitute a fully federally financed and administered system. "Our present system should be improved upon rather than dismantled in favor of a costly, inflexible federal system."

"The budgetary impact on the federal government, Weinberger maintained, "is simply unacceptable."

Representative PSROs

The government's procedures to assure that Professional Standards Review Organizations (PSRO's) represent physicians in their local areas have been announced.

The PSRO law requires that the HEW department before entering into an agreement with an organization to be the PSRO for an area, must notify the physicians of that area of the intent. The physicians then have the opportunity to object to a specific organization being named as the PSRO. The method to be used in notifying the nation's physicians of the proposed PSRO's and the subsequent steps to be taken in assuring that the organizations are acceptable to the physicians are detailed in the *Federal Register* of April 16.

"In keeping with the PSRO legislation, we have developed procedures to assure that the organizations established as PSRO's throughout the country are truly representative of the physicians in each of the PSRO areas," HEW Secretary Caspar Weinberger said. "It is the local physicians who will plan, operate and control the PSRO in each area, and, therefore, the organization designated as the PSRO must be their organization," he said.

When the Secretary has determined that a local physician organization is qualified to perform the PSRO functions required by law, he will notify the area's physicians and other health professionals by announcements in the local press and mailed notices to physician and hospital organizations active in the area. The notice will also be published nationally in the *Federal Register*.

The notice will announce the Secretary's intent to enter into a financial agreement with a specific organization, describe the organization, and indicate that active, practicing physicians in the area have 30 days in which to protest the proposed selecton. If less than 10 per cent of the local area's doctors object to the proposed organization, the law provides that the Secretary can designate and fund the PSRO that he has chosen. However, if more than 10 per cent do object, the Secretary will conduct polls of the physicians in the area. HEW will mail a ballot to each doctor who practices in the area on which he can indicate whether the organization provisionally selected by the Secretary does or does not represent him.

A 30-day period will be allowed for the ballots to be returned. If more than 50 per cent of the respondents to the poll indicate that the organization does not represent them, the Secretary will no longer consider that organization for PSRO designation. If less than half object, the Secretary, by law, can conclude his agreement with the local PSRO.

HEW Critiques AMA Kit

The government has labeled as "factually inaccurate and misleading" a kit on Professional Standards Review Organizations (PSRO's) prepared by the American Medical Association.

In a critique of the kit, the Health, Education and Welfare Department said many of the PSRO review functions actually are embodied in the Social Security Act's Medicare and Medicaid provisions that were approved long before PSRO.

The HEW paper contends that the purpose of PSRO "was to give practicing physicians priority in undertaking the review of care provided rather than have the review performed by those outside the medical profession."

Contents of the kit, entitled "PSRO—DELETERIOUS EFFECTS," have been criticized by HEW and Senator Wallace Bennett (R., Utah), chief Congressional sponsor of the PSRO provision. The kit was prepared and distributed by the AMA at the behest of the AMA's House of Delegates to alert the medical profession to the dangers of such a review system.

Cooper Appointment

Theodore Cooper, M.D., has been appointed deputy to Assistant HEW Secretary for Health, Charles Edwards, M.D. Dr. Cooper is director of the National Heart and Lung Institute. Henry Simmons, M.D., who has been serving as Dr. Edwards' right hand man, will continue to hold a deputy position but will concentrate henceforth most of his efforts at directing the Professional Standards Review Organization (PSRO) program. Dr. Cooper is regarded as one of the government's most able health officers. One of the first heart transplant researchers, he is a renowned expert on the heart.

VA Chief Named

John Chase, M.D., a Veterans Administration career medical official for 22 years, has been appointed Chief VA medical director. VA Administrator, Donald Johnson, also announced the appointment of Laurance Foye, Jr., M.D., as deputy chief medical director of the agency. Dr. Chase is succeeding Marc Musser, M.D., who resigned. Foye replaces Benjamin Wells, M.D., who retired last January 23.

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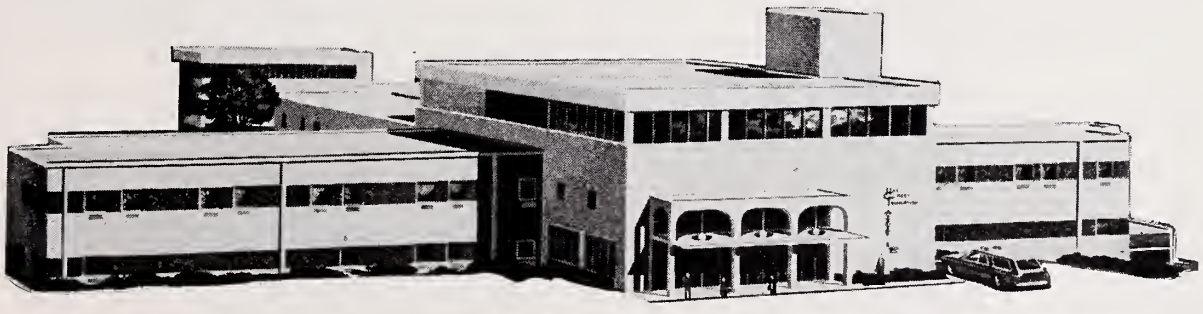
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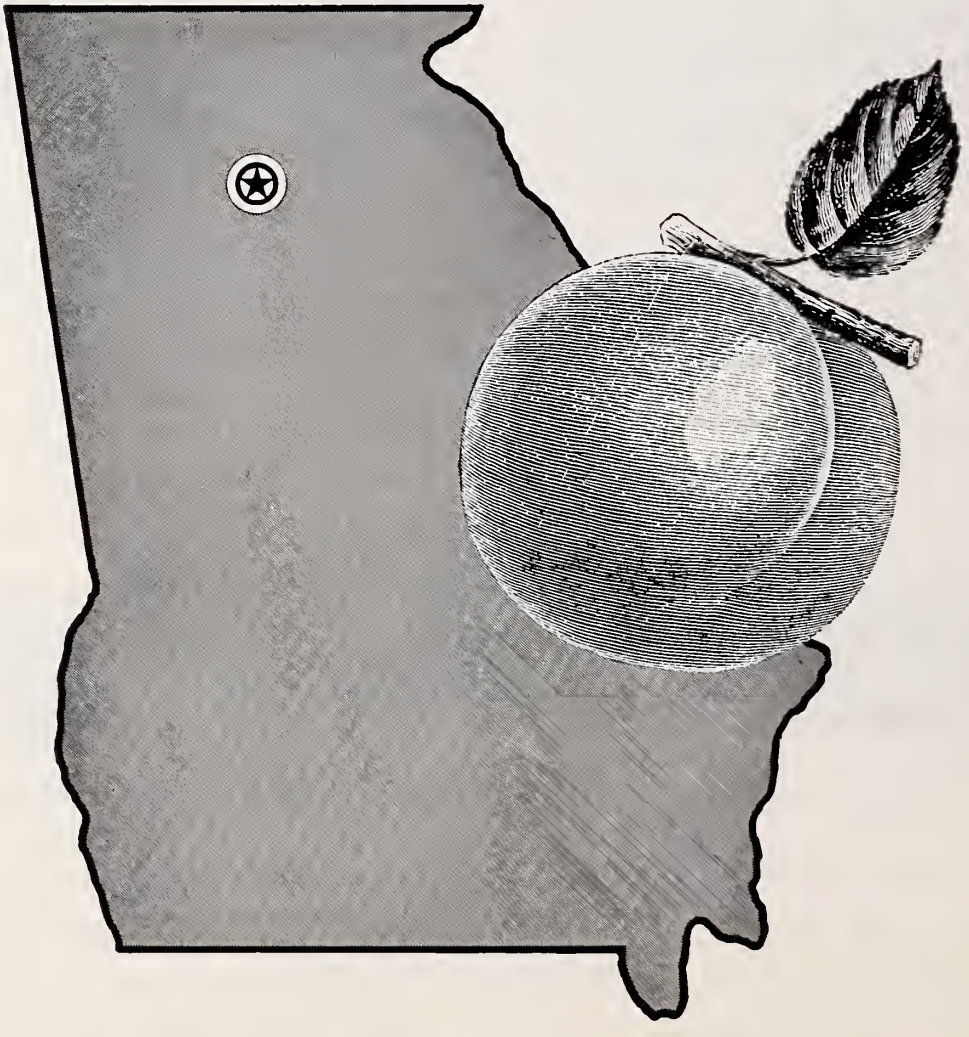
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Meet the Leading Candidates for Governor
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THE COVER

The excitement of another gubernatorial race is upon us as a field of candidates races toward the state's highest office. Read about the backgrounds of seven of these candidates and their comments on the Department of Human Resources on page 293. Design by Atlanta artist Bob Hamill.

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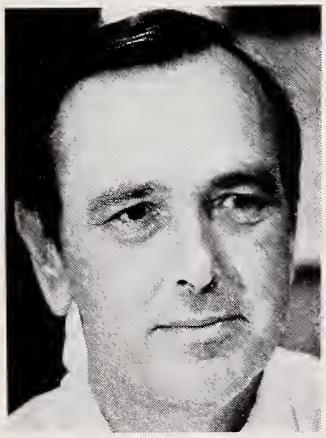
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The Candidates Speak to the Medical Profession

Seven of the leading candidates for governor have been asked to respond to the question, "What action would you take as governor to restructure the Department of Human Resources to better assure that it serves the needs of the people of Georgia?" Brief biographical information precedes their statements to better familiarize you with the candidates who are listed in alphabetical order. Important election dates include: August 13—General Primary; September 3—General Primary Runoff; November 5—General Election; November 26—General Election Runoff.

GEORGE BUSBEE has served as a member of the Georgia House of Representatives for 18 years in which time his special concerns have been vocational education and the junior college program, reform legislation for Medicaid and welfare programs and in 1974, he authored the Campaign Financing Disclosure Act. Busbee was floor leader from 1963 to 1966 and in 1967 was first elected as majority leader, a position he has held continuously since then. In 1965 he was picked by the Capitol press corps as one of the most respected legislators.



Busbee was born in 1927 to a Vienna, Georgia farming family. He served in the U.S. Navy during World War II and attended Abraham Baldwin Agricultural College, Duke University and the University of Georgia receiving degrees in business and law. Busbee practices law in Albany where he lives with his wife, the former Mary Beth Talbot of Ruston, La., and their four children. He is a member of Sherwood Baptist Church.

The Human Resources Department was created by Governor Carter during his reorganization of state government for the stated purpose of eliminating duplicate services and saving large sums of money for the state.

Although we have had some problems in the other departments created during Governor Carter's reorganization, our major problems have centered around poor delivery of services, lack of input at the policy level from both knowledgeable private and professional resources, and low morale in the Human Resources Department due to the overstratification in administering the Department.

During the reorganization of this Department, I met with the representatives of the Medical Association of Georgia and representatives of the Governor in an effort to work out a compromise that would have prevented some of the problems we now have.

Some of the difficulties of reorganization have been compounded by the development of an area network within the Human Resources Department, supposedly to facilitate the administration of services from the district level, but in fact having the effect of placing area policy decision making below the department level, which creates confusion in the area of authority and responsibility.

I have met with many groups interested in delivery of services in this department, including medical doctors, and I frankly have some difficulty in ascertaining how much of the problem is a result of reorganization and how much is due to the lack of administrative ability within the department.

I strongly feel that some of the problems in this department stem from the appointment of administrative personnel who are not from the mainstream

of the professional groups they supposedly represent. This, in itself, creates problems.

There are some basic differences between health services and the other services contained in the Department of Human Resources.

Health, as a profession, is regulated by state law. This is not true of the Department of Family and Children Services, Vocational Rehabilitation, or Court Services.

Beyond the regulation by state law, health is subject to a great deal more local program control than either of the above three.

Local control of health is afforded by the Boards of Health representing the communities which contribute funds toward the support of the agency's activities.

While I am not in favor of going back to these agencies as they existed prior to reorganization, I do feel that some restructuring is going to be required in order to meet many of the problems we have in the Human Resources Department.

I am now in the process of meeting with various professional groups and organizations that are directly affected and involved in the services rendered by this department, including representatives from the medical profession.

Though I have not come up with what I consider a final structural arrangement for this department, I am now studying the feasibility of a Division of Health consisting of physical health, mental health and environmental health headed by a Director.

Administrative layers must be reduced as much as possible to facilitate efficiency, and better delivery of quality health care.

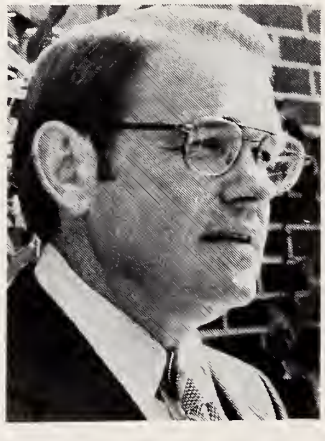
There must be a procedure to insure input from health related organizations and professions.

This could be accomplished through the development of three professional Advisory Boards. I propose as Governor to establish Advisory Boards in the various health service areas that would provide information, advice and counsel directly to the Governor. These Boards would be composed of professional and private individuals with knowledge in the various health service areas.

These Boards would relate to physical health, mental health, and environmental health.

As Governor, I intend to use this type advisory group in the proposed restructuring within this department and for the administration of the services thereafter.

DAVID H. GAMBRELL was appointed to the U.S. Senate in 1971 upon the death of Richard B. Russell and served two years as a member of the Committee on Banking, Housing and Urban Affairs and the Select Committee on Small Business. He was especially active in the fight against inflation and sponsored reforms in the welfare system, was the author of legislation to promote rural development and to restrict forced school busing. Gambrell went to Washington after serving in Georgia as chairman of the Democratic Party. He has practiced law since 1951 and is senior partner in the firm of Gambrell and Mobley, organized in 1963. He has been active in the American Bar Association, served as Trustee and general counsel of the Atlanta Crime Commission and was director of the Atlanta Legal Aid Society and State YMCA.



The native Atlantan was born in 1929 and graduated from Davidson College and Harvard Law School with honors. Gambrell and his wife, the former Luck Flanders of Swainsboro, have four children. He is a member, Elder and men's Bible class teacher at the First Presbyterian Church of Atlanta.

I propose to put the Department of Human Resources under experienced management and control, and to avoid introducing any more experimental and controversial programs into its operations.

The present difficulties with the Department resulted from its size, the introduction of untried and experimental programs, combined with the absence of experienced management. Should the new administration find it impossible to bring order into the operations of the Department's business, it would then be time to consider altering the Department's structure.

The business of the Department is too vital and too sensitive to undergo further radical alterations simply because the present structure has not been administered in a mature manner. I will not permit this Department to continue to or become a political football under my administration.

HARRY C. JACKSON of Columbus has served as a Georgia state senator for six terms, twice serving as president pro tempore of the Senate. He has served as chairman of the Business, Trade and Commerce Committee, vice chairman of the University System of Georgia and secretary of the Senate Administrative Affairs.



Jackson was elected "Georgia Engineer of the Year" in 1971 and owns Morton Machine Works, Inc., manufacturers of dyeing and drying textile machinery, stainless steel valves, pumps and tanks. His degree in mechanical engineering came from Auburn University, and he also attended Georgia Military College. Jackson is a Rotarian, Mason, Shriner, member of the American Legion and Committee of 100 of Emory University. He serves on the Board of Directors for two Columbus banks.

Jackson was born in Columbus and served in the U.S. Army during World War II. He and his wife, the former Helen Lovein Jackson, have two children. Jackson is active in St. Paul Methodist Church of Columbus.

There is but one salient issue in this governor's race and indeed, when correctly analyzed, there is but one burning issue in any political race—improving the quality of life. An important question then is: what can be done to improve the quality of life in Georgia?

We know that Georgia is well below the national average in medical services available to our people —having 65 per cent of the national average in physicians per 100,000 population and only 50 per cent of the nurses—so it is mandatory that the available services be best utilized.

It then becomes ludicrous for state government to abuse the medical profession as has been the case in the so-called governmental reorganization, a bureaucratic move that created the Department of Human Resources.

When administrative fuzzy heads begin tampering the professional works with absurd demands on medical professionals, there are inevitable results such as the loss of Dr. Stewart Ginsberg at the Georgia Mental Health Institute last year.

The people of Georgia realize that the medical profession is special, that the ability to prolong and save lives is unique and that the practice of mere administration can in no way take precedent. Said another way, medicine belongs to the medical profession.

I do not believe in restructuring for the sake of rebuilding, no more than I believe in reorganization for the sake of organization.

But I do feel strongly that the Department of Human Resources must be broken down. The Department of Health must be a separate division of government, placed under professionals trained in health care and vocational rehabilitation must be recognized as primarily an education process, not a social function.

In essence, I feel that those areas of government that concern the medical profession in particular should respond to the needs of the profession. Boards that govern these departments must be governed by professionals who know and understand the problems.

We don't need to strengthen our sprawling bureaucracy by spreading it over the medical profession. To the contrary, to be fully effective, medicine must be freed from the logisticians and politicians who insist that planning and strategy are more important than performance.

BERT LANCE, former commissioner of the Georgia Department of Transportation, was born in Gainesville in 1931 and reared in Young Harris in Towns County where his father, Dr. T. J. Lance, served as president of Young Harris College. He attended Emory University, the University of Georgia, the School of Banking of the South at Louisiana State University and the Stonier Graduate School of Banking at Rutgers University.



Lance went to work at the Calhoun First National Bank in 1951 as a teller and in 1963, at the age of 32, was named president and chief executive officer. He is a member of the Board of Trustees of Georgia State University and Reinhardt College in Waleska, is a member of the Committee of 100 for Emory, member of the Board of Counselors of Oxford College of Emory and member of the President's Advisory Council of Agnes Scott College. As a spokesman for the free enterprise system, Lance serves as chairman of The Chair of Private Enterprise at Georgia State University.

Mr. and Mrs. Lance, the former LaBelle David of Calhoun, have four sons and are members of the First United Methodist Church of Calhoun.

First of all, I certainly intend to insure that, if elected, I would be in a position to have proper communication with the members of the Medical Association of Georgia with regard to health care delivery problems and any other medical problems with which the state might be confronted. I certainly shall maintain an open-door policy and

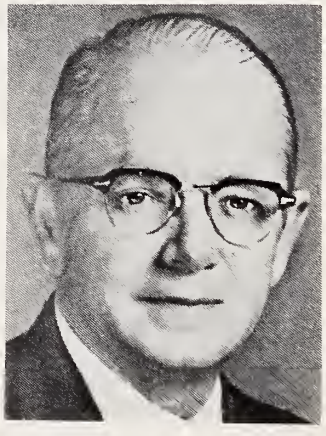
will always be available and will encourage the members of the medical profession and the governing officials of the Medical Association of Georgia to discuss with me their thoughts, ideas and suggestions about any aspect of the health care services we should be trying to make available to the people of Georgia. It will be absolutely necessary for me to rely heavily upon the professional advice of those in the medical profession in order to insure we have the best health care delivery system possible for the people of our state. I should like to go one step further and suggest that a regularly scheduled discussion period be held between the Governor and the officials of the Medical Association of Georgia in order that we might try to measure how effective our service really is.

With regard to the Department of Human Resources, it would be my plan to restructure the Department whereby we would have two Deputy Commissioners, one for health and one for welfare. The Deputy commissioner for health should be a physician with a reputation for administration and innovation in the field of health care delivery services.

In addition, I intend to explore in great detail the proposals to create a separate department for mental health. I believe this would put the delivery of programs for the mentally ill on the proper basis and would show the importance of the mental health program in Georgia to all the people of our state and would set the proper priority for such a great need and problem.

I will not go into further detail at the present time, but I certainly do need and must have the participation and input of the members of the medical profession of our state with regard to what certainly is one of the primary and most important services offered by our state government.

LESTER MADDOX served as governor of Georgia from 1966 to 1970 then became the first former governor to be elected to the office of lieutenant governor since that position was created in the 1945 Constitution. He names as his major accomplishments during his administration opening up government to all the people, establishing sound business practices in state government, prison reform, support for law enforcement officers, advances in public education, progress in mental health programs, accelerated highway construction and improvement and increases in benefits for Georgia workers.



Maddox was born in Atlanta in 1915 and educated in its public schools. At 19 he was made supervisor of an industrial plant, and in 1944, he and his wife, Virginia, opened their first restaurant, followed three years later with the opening of his famous Pickrick Restaurant. Maddox is a member of the York Rite and Scottish Rite Masons, a Moose and member of numerous other civic, fraternal and honorary organizations. Mr. and Mr. Maddox have two sons, two daughters and nine grandchildren. They attend North Atlanta Baptist Church.

I think it is obvious that reorganization has created confusion and inefficiency in several agencies of state government, and especially in the Department of Human Resources. The waste, inefficiency and deterioration in the quality of health care currently being delivered is of major concern to me and to many other Georgians. Our people deserve better, and they are paying for better.

I intend to do everything within my power to return the responsibility for public health care to those with the training and experience to do the job by removing health care from the jurisdiction of DHR and re-establishing a separate agency similar to the Old Department of Public Health. The governing board would be made up of physicians, dentists, pharmacists and representatives of other professional and governmental organizations. I think the director should be a medical doctor.

I am a firm believer in going to experts in a field when I have an important job to be done. Just as I would not put a physician in charge of Georgia's highways, neither would I put an engineer, a plumber or a banker in charge of our health services.

There are other problems with DHR which are crying for attention, just as there are with some of the other reorganized agencies. However, I do not think rash actions on my part would solve problems created by other rash actions.

As Georgia's next Governor, I intend to seek the counsel of experts, including Georgia's doctors, to determine which parts of reorganization are good and need to be preserved, and which parts have produced inefficiency, waste, poorer services for the people, needless bureaucracy and a generally less representative state government. These latter conditions, where found, will be corrected without any regard whatsoever for the political consequences. State government is designed to serve the people. The people pay for good services with their tax dollars. I intend to see that the people get what they pay for.

BOBBY ROWAN of Enigma was 26 when first elected to the Georgia State Senate 12 years ago. He has served continuously since then and in 1968 was named an Outstanding Senator by the Capitol press corps. In 1967 he was named chairman of the Committee on Institutions and Mental Health and has sponsored legislation such as the "Mental Health Bill of Rights." Other special concerns have been programs for mentally retarded, education of children with special problems or handicaps, maternal health care, early childhood development programs, election codes and conflicts of interest and protecting vital areas of land.



Rowan was born in 1935 to a Nashville, Ga. farming family, the middle of nine children. He attended Abraham Baldwin Agricultural College and the University of Georgia, from which he was graduated with a major in agronomy. Through the 4-H clubs, as a state officer, and at the University of Georgia, as student body president, he was active in political affars. He served his military obligation, then returned to his home in Berren County. Rowan marred Amelia McMillan, who died in 1973, and the two taught school, started a farm and family of two boys.

Governor Carter's reorganization plan dealing with Human Resources came before the Senate four times. I voted against that legislation on all four occasions because I felt the process of organizing such a large department would be traumatic. I believe my judgement has proved valid. Now that a great deal of money and time has been poured into reorganization, however, I would be reluctant to impede the delivery of health care for another two years by disbanding the Department and reorganizing it again unless that appears essential. I believe the Department can operate effectively provided authority is properly allocated among its divisions, its personnel are well-qualified, and its programs are professionally sound. As governor, my initial steps will be:

1. I will seek advice from competent professionals and management specialists to define job descriptions clearly.

2. I will substitute independent professional evaluation for political rhetoric. Instead of politicians arguing about the Department, it should be evaluated by competent professionals. Few politicians know how to organize a health delivery system. I would much prefer to listen to sound advice from doctors, nurses, and other related professionals.

3. The divisional level within the Department must be strengthened. The Commissioner of Human Resources should coordinate the activities of the divisions, but division directors should be responsible for implementing Board of Human Resources policies.

4. The Department has repeatedly effected major changes in personnel and programs with an air of secrecy and without public discussion. These decisions often seem to be implemented irrationally in such a way as to maximize the resulting shock, I will insist that no such major changes occur in the future without prior full, free, and open public discussion.

5. Based on recommendations of professionals after thorough evaluation of the Department, I will make whatever organizational changes are necessary. If it is found that the Department cannot meet Georgia's needs effectively, then certainly it will be dismantled. I will not, however, destroy the Department as soon as I take office, as some suggest, because that would accomplish nothing but temporary relief of valid frustrations many feel because of the problems which now exist. I am convinced that qualified professionals can make the Department work without going through the agonies and cost of reorganization again. I would offer the Governor's aid in a good faith effort to meet that goal.

GEORGE T. SMITH served as lieutenant governor of Georgia from 1967 to 1970, capping off an eight year career as a member of the House of Representatives for which he was speaker four years. Smith has had a long history as a public servant which began with service as city attorney for Cairo starting in 1949. He was county attorney for Grady County, Cairo City solicitor, and attorney for the Grady Board of Education.



Smith was born in Mitchell County in 1916, attended Middle Georgia College, Abraham Baldwin Agricultural College, where he was president of the Student Body and Student Council, and Lumpkin Law School of the University of Georgia. Smith served in the U.S. Navy during World War II and received several awards, citations and medals.

Civic and community service occupies much of his time as he is district governor for the Kiwanis Club, member of the Bar Association, active in Cancer Fund Drive and Community Chest, American Legion, Veterans of Foreign Wars and the Moose Club. He is a deacon and Sunday School teacher at First Baptist Church of College Park. Smith is married to the former Eloise Taylor.

The Department of Human Resources has been a target of heated controversy ever since its inception. Many of those whom it serves complain that it is a lumbering and costly bureaucracy which fails to

meet their needs. Members of the medical profession tell me that it has compounded their problems by bogging them down in red tape and making it almost impossible for them to collect their fees in any reasonable length of time.

I have launched an intensive study of the Department, talking with officials, the people it serves, concerned physicians, social workers and medical associations and the public at large. To say now how I would restructure this department would be premature. I can only promise that as governor I will do all in my power to see that this department is restructured to serve the people of Georgia and our dedicated professionals more effectively.

American College of Surgeons to Hold 60th Annual Clinical Congress in October

The world's largest meeting of surgeons, the 60th annual Clinical Congress of the American College of Surgeons, will be held in Miami Beach, Fla., October 21-25. The meeting will be the first to be held in the newly-expanded Miami Beach Convention Center now nearing completion. Close to 20,000 surgeons, guests, and members of other medical professions are expected to attend the Congress.

The Clinical Congress Program will include:

- 17 postgraduate courses. The American College of Surgeons has been accredited for its continuing education programs by the American Medical Association. Each hour of the program is equivalent to one hour of Category I credit toward the AMA Physician's Recognition Award.
- More than 260 research-in-progress reports called the Forum on Fundamental Surgical Problems.
- More than 50 panel discussions and symposia on general surgery and the surgical specialties.
- Live telecasts of operations originating from Jackson Memorial Hospital, Miami.
- More than 130 films and Ciné Clinics, including those in "spectacular surgery."
- A wrap-up of "What's New in Surgery."
- More than 350 scientific and industrial exhibits.
- Convocation ceremonies for initiates inducted into fellowship in the College on Thursday, October 24. Fellowship is awarded to those surgeons who have fulfilled comprehensive requirements of acceptable medical education and advanced training in surgery or one of its specialties, and who have given concrete evidence of high competence in their field, good moral character and ethical practice. Honorary Fellowships will be awarded to distinguished international scholars in the same ceremonies.

A pre-Clinical Congress course in Scientific Communications designed to improve competence of scientists in self-expression through writing and speaking, will be held October 19 and 20 in the Doral Beach Hotel, Miami Beach. There is a separate $100 fee for this course. A special registration form is available from the College's Communications Department.

Registration is free for Fellows of the College whose dues are paid to December 1973; initiates; members of the candidate group; and surgical residents. Non-Fellows pay $90. Non-Fellow physicians in the federal service pay $50. Everyone who enrolls in one of the 17 postgraduate courses, including those who register free, must pay the fee for the course selected.

PEACHTREE-PARKWOOD ANNOUNCES COMPREHENSIVE PROGRAM FOR CHILD AND FAMILY

The Board of Directors of Peachtree and Parkwood Mental Health Center and Hospitals has announced the decision to establish a comprehensive diagnostic and treatment facility for children, adolescents and their families, the first such private center in Georgia.

The child and family treatment program will be staffed by a team of child psychiatrists, psychologists, social workers, special education teachers and nurses. Day hospital and therapeutic education services programs will be designed for children or adolescents who need a full day treatment program but are able to live at home.

Peachtree-Parkwood hopes to open the center in August on Cliff Valley Way in Northeast Atlanta. The hospital opened the first private adolescent inpatient service in Georgia in 1972.

The frequency and types of cardiovascular problems are outlined with a discussion of the pathophysiology and clinical findings.

Cardiovascular Complications of Drug Abuse

JOEL M. FELNER, M.D., ROBERT C. SCHLANT, M.D., *and* J. WILLIS HURST, M.D., *Atlanta**

THE MOST TRAGIC VARIETY of cardiovascular disease is related to drug abuse. The word tragic is appropriate for two reasons: (1) The cardiovascular conditions produced by drug abuse are often fatal and (2) the conditions emphasize the serious psycho-social ills of our times.

Major cardiovascular disorders have resulted from many drugs, including the following: the parenteral self-administration of a variety of substances; the improper oral use of narcotics, barbituates, and amphetamines; and glue and solvent sniffing. The illnesses are due to drug contaminants, unsterile injection techniques, and/or the drugs themselves. Even drugs such as phenothiazines and other psychotropic agents given for "legitimate" reasons may produce tragic results.

The purpose of this report is to highlight the types of cardiovascular problems due to illicit drug abuse (Table 1); to indicate the frequency of some of the problems; and to discuss the pathophysiology and clinical findings associated with the conditions.

TABLE 1
CARDIOVASCULAR COMPLICATIONS OF DRUG ABUSE

1. Cardiac
   a. Infective endocarditis
   b. Myocardial disease
   c. Pulse and blood pressure changes
   d. Cardiac dysrhythmias and electrocardiographic abnormalities
2. Vascular
   a. Local thrombophlebitis
   b. Local arterial occlusion
   c. Aneurysms; traumatic and mycotic
   d. Local arteritis
   e. Embolic phenomena
   f. Angiothrombotic pulmonary hypertension
   g. Necrotizing angiitis
3. Danger to Fetus

Sources of Information

The medical literature on cardiovascular disease due to drug abuse is growing rapidly. The carefully reviewed articles used to produce this report are shown in the bibliography. The information used as the basis for this report was derived from six sources: (1) the literature; (2) our personal experience on the medical service of Grady Memorial Hospital, Atlanta, Georgia; (3) information supplied to us by Dr. Arnold Weissler, professor and chairman of the Department of Medicine of Wayne State University School of Medicine in Detroit, Michigan;[1] (4) information supplied by Dr. Lawrence Power, Chief of the Medical Service at Detroit General Hospital, Detroit, Michigan;[1] (5) information supplied by Dr. Frank Lau, professor of Medicine and director of the Division of Cardiology, University of Southern California in Los Angeles[2] and (6) publications of and communications with Dr. James J. Nora, director of Pediatric Cardiology, School of Medicine, University of Colorado.

Magnitude of the Problem

It is difficult to determine the exact magnitude of the problem because many patients with cardiovascular complications of drug abuse either do not see a physician or may not be admitted to the hospital for detailed examination.

At Grady Memorial Hospital in Atlanta from March 1971 through November 1972, 269 of 9,000 patients discharged from the medical service were

* From the Department of Medicine of Emory University School of Medicine and Grady Memorial Hospital in Atlanta. Supported in part by NHLI Training Grants Nos. H.E. 05731 and H.E. 5653.
Dr. Felner is a Cardiac Fellow at Emory, cardiovascular trainee supported by NHLI Training Grant No. H.E. 05731. Dr. Schlant serves as director of the Division of Cardiology of the Department of Medicine at Emory and Dr. Hurst is professor and chairman of the Emory Department of Medicine, 69 Butler St., S.E., Atlanta, Ga. 30303.

drug addicts; many others were patients who received treatment in the emergency clinic. In November 1972, at Detroit General Hospital, six to twelve of the 125 medical beds were occupied by patients with endocarditis or other cardiovascular illnesses due to drug addiction, i.e., 5 to 10 per cent of the total general adult medical beds in this hospital are presently occupied by drug addicts with cardiovascular complications.[1] An additional 5 to 10 per cent of the total patient population of the adult medical wards of that hospital are estimated to have non-cardiovascular complications of drug abuse such as hepatitis or psychosis. At Harper Hospital, also in Detroit in 1972, at least two to four of the 45 medical beds were estimated to be occupied at any one time by addicts with endocarditis.[1] And in the 12 month period ending November 1972, at Los Angeles County General Hospital (LACGH), which has approximately 1,600 medical beds, from 10 to 20 beds were occupied by patients with endocarditis; 90 per cent of these are drug addicts.[2]

Cardiac Complications

A. Infective Endocarditis. The most important *cardiac* complication of drug abuse is acute infective endocarditis. Recently, on the medical service of Grady Memorial Hospital in Atlanta, seven narcotic addicts with endocarditis were treated; four were admitted within a four-week period. Their ages ranged from 17 to 27; four were men; all abused heroin; and four had cutaneous abscesses which required drainage. Of the five patients with positive blood cultures, four had penicillin-resistant staphylococcus aureus isolated; the other had Group A streptococcus. Prior antibiotic therapy probably contributed to the negative blood cultures in one other patient. The mitral valve was involved in the one patient with pre-existing rheumatic mitral valve disease. The other six patients had right-sided endocarditis. Embolic phenomenon (hepatic, cutaneous, renal and pulmonary) complicated the courses of six of the patients. All patients were treated successfully.

In a more extensive survey[2] during the year ending June 30, 1972, 146 patients at LACGH, suspected of having infective endocarditis were studied; 66 cases were confirmed clinically or pathologically. Of these, 37 were known drug addicts; 53 (80 per cent) had positive blood cultures. The isolates and number of deaths for both groups are shown in Table 2. There were three patients with pre-existing rheumatic heart disease; two in the non-addict group and only one in the addict group. The four non-addict patients with pneumococcal endocarditis

TABLE 2
ENDOCARDITIS AT LOS ANGELES COUNTY GENERAL HOSPITAL

(7-1-1971 to 6-30-1972)	Addicts	Deaths	Non-Addicts	Deaths
Enterococci	13	2	5	2
Candida species	8	4	0	0
S. aureus	5	0	1	0
Gram-negative rods.	5*	1	2	0
Other gram-positives	4	0	8	4**
Bacteroides	0	0	1	1
Hemophilus	0	0	1	0
Unknown	2	0	11	6
Total	37	7	29	13

* Four had pseudomonas isolated.
** All had pneumococci isolated.

all had meningitis and, presumably, brain abscesses which accounted for the very high mortality. All eight of the Candida group had aortic valve involvement, one also had involvement of the mitral valve. The four survivors all had valve replacements.

A report by Cherubin in 1968[3] also compared infective endocarditis in narcotic addicts with a control group of non-addicted patients. The mean age of the addict group, 75 per cent of whom were men, was 31 as compared with a mean age of 41 and equal sex distribution in the non-addict group. The most commonly affected valves, in order of frequency, were aortic, mitral, and tricuspid. Although only 13 per cent of the addict group had tricuspid involvement, it was involved in less than 2 per cent of the non-addict group. In the addict group there was a marked increase in frequency of staphylococcal, gram-negative bacterial, and Candida valve infections. Staphylococci were isolated in 44 per cent of the addict group as compared to 25 per cent of the non-addict group (but only 17 per cent of the age-matched controls). There were no cases of *streptococcus viridans* in the addict population, whereas the majority of the 71 per cent of streptococcal isolates in the non-addict population were *S. viridans*. Pre-existing heart disease was less frequent in the addict group than in age-matched controls with infective endocarditis.

In addition to Cherubin's study, 118 previously reported cases of endocarditis due to narcotic abuse were analyzed (Table 3).[4-10] Seventy-six of these 118 patients (64 per cent) used heroin exclusively and 42 (36 per cent) used a mixture of illicit drugs. Ninety-nine (84 per cent) were caused by bacteria, predominantly staphylococcus aureus (45 cases) and 19 (16 per cent) were caused by Candida species. The endocarditis occurred on the left side in 76 cases (65 per cent); on the right side in 36 cases

(31 per cent) and involved both sides of the heart in six cases. The aortic valve was most commonly involved, followed by the tricuspid and mitral valves (Table 3). Of the 118 patients, 25 had pre-existing heart disease; this included 15 cases of those with bacterial endocarditis (10 rheumatic, three luetic, and two congenital) and 10 cases of those with Candida endocarditis (eight rheumatic and two congenital). Seventy-six of the 118 patients (65 per cent) died; of these 99 had bacterial endocarditis and 19 Candida endocarditis.

The incidence of endocarditis in patients with narcotic addiction is significantly higher than its incidence in the general population. Although this incidence is difficult to estimate, Cherubin[3] in 1968 calculated the minimum incidence in addicts, based on an addict population in New York City of 50,000 persons (at seven cases per year), to be 1.4/10,000 per year. For comparison, the rate of deaths attributed to endocarditis for the city as a whole is only 0.045/10,000 per year.

Endocarditis in addict patients differs from endocarditis in the general population. Of the 118 cases of endocarditis in addicts previously reported, exclusive of Cherubin's group, 36 (30 per cent) had right-sided endocarditis, with involvement of the tricuspid valve in all but two of the 36. This distribution contrasts sharply with the pattern of valve involvement in non-addict patients with infective endocarditis, in whom right-sided valves are affected in less than 5 per cent.[11] Although it has been emphasized that endocarditis in a narcotic addict is frequently right-sided, it should also be emphasized that *left-sided endocarditis is still more than twice as common* as the right-sided endocarditis in the addict population (Table 3).

TABLE 3

VALVE INVOLVED IN 118 PATIENTS WITH ENDOCARDITIS REPORTED IN THE LITERATURE[4-10]

	Total
A. Bacterial Isolates	
Left-sided	
Aortic	25
Mitral	17
Aortic and Mitral	18
Total	60 (60%)
Right-sided	
Tricuspid	32
Pulmonic	1
Total	33 (33%)
Mixed	
Mixed	6
Total	6 (7%)
B. Candida Isolates	
Right-sided	
Tricuspid	2
Pulmonic	1
Total	3 (16%)
Left-sided	
Aortic	8
Mitral	6
Aortic and Mitral	2
Total	16 (84%)
Total	118

The incidence of known pre-existing heart disease also differs markedly between the addict and the non-addict populations with endocarditis. In the addict group only 25 of the 118 patients reported in the literature[4-10] and only one of the 37 patients in the LACGH series had pre-existing valvular disease. On the other hand, evidence of an antecedent valvular lesion is usually found in 80 to 90 per cent of non-addict patients with endocarditis.[12] None of the 33 patients with right-sided lesions (Table 3) due to bacterial endocarditis had pre-existing valvular lesions. The unusually high incidence of endocarditis on apparently normal heart valves in addicts is probably explained by the repetitive bacteremia in narcotic addicts and by the virulence of the organisms isolated, especially the coagulase-positive *staphylococcus aureus,* which accounted for 42 per cent of the 118 cases. Even more remarkable is the fact that *S. aureus* was isolated from all but six of the 34 addict patients with endocarditis of the tricuspid valve. A similar incidence was noted in our small series at Grady Hospital and in a recent series in which amphetamine was injected intravenously.[13] The higher incidence of infections with Candida or gram-negative bacilli in addict patients with endocarditis probably reflects the careless sterilization techniques and unusual methods of injection used by addicts. Candida infections, which notoriously affect damaged valves, occurred less frequently in addicts with right-sided than in those with left-sided endocarditis. The increasing number of isolates of pseudomonas in patients with tricuspid endocarditis has been noted over the last year (Table 2). Although endocarditis arising in narcotic addicts is relatively rarely due to alpha-streptococci, those addicts with pre-existing heart disease may present in a manner similar to non-addicts with an unexpected high incidence of *S. viridans* endocarditis, especially since addicts notoriously have poor dental hygiene, use sputum as diluents, hold needles in their mouths and reuse disposable needles, making sterilization impossible.

Although the reported death rate in the cases of infective endocarditis in drug addicts is high, the recent experiences at Grady Memorial Hospital and LACGH suggest that treatment is effective in the majority of patients with staphylococcal endocarditis. In addict patients with infection due to gram-negative organisms or Candida infections (especially those requiring valve replacement), treatment is

complicated by difficulty in completing the full course of antibiotic therapy and by the likelihood of reinfection should a prosthetic valve be required if the addiction is not cured. Recently, however, a new approach to the management of uncontrolled right-sided endocarditis (usually pseudomonas-induced) was proposed by Robin, et al.[14] They surgically excised the tricuspid and/or the pulmonic valve(s) without prosthetic replacement. In spite of the ventricularization of pressures in the right atrium and central veins, this procedure has proved to be an effective mode of therapy; 10 of 11 survivors have been followed for up to 24 months; however, further investigation is needed before this mode of therapy can be routinely recommended.

Infective endocarditis should be suspected in any addict who presents with either fever of unknown origin, pneumonia, embolic phenomena, or positive blood cultures (especially with *S. aureus,* Candida, enterococcus or gram-negatives). Fever can be the sole manifestation of endocarditis even if cultures are negative. Since endocarditis in narcotic addicts is often fulminating and generally follows the pattern of an "acute" endocarditis with frequent embolization and marked valve destruction, one must suspect this condition and begin treatment early if survival rates are to be improved. Although addicts may develop septic pulmonary emboli following thrombophlebitis without endocarditis, it seems wise to treat addict patients who have septic pulmonary emboli as if endocarditis were present since tricuspid endocarditis may occur in the absence of a heart murmur. In addition, since one-third of patients with staphylococcal endocarditis in Cherubin's series[3] had been admitted and treated for staphylococcal pneumonia immediately preceding the onset of signs or symptoms of infective endocarditis, it is important that addicts treated for penumonia be observed for a period without antibiotics after completion of therapy, to avoid overlooking the early signs and symptoms of endocarditis. The same is true for addicts with acute meningitis, which may also occur and be the dominant and/or presenting feature.

In narcotic addicts the most *characteristic* cardiac lesion (but not the *most common* cardiac lesion) is acute endocarditis of the tricuspid valve. At times, the diagnosis of infective endocarditis of the tricuspid valve is extremely difficult because there is usually no apparent pre-existing tricuspid disease (as reported in tricuspid valve endocarditis in a non-addict population),[11] and because the signs of tricuspid valve infection are frequently inconspicuous or atypical. In some patients, tricuspid involvement is manifested by a clearcut murmur of tricuspid regurgitation. The classic clues of tricuspid endocarditis are repeated episodes of septic pulmonary emboli with resultant infarction and occasionally pneumonia, cavitation, and isolation of staphylococci from the sputum. Although systemic emboli to brain, spleen, and kidney are more suggestive of left-sided endocarditis, they can also be seen with right-sided lesions.[15]

In summary, right-sided endocarditis in drug addicts almost always affects an apparently previously normal tricuspid valve although one can never eliminate the possibility of there having been a small minor congenital defect that served as the nidus of the subsequent valve infection and that might even be destroyed by the subsequent infection. It is most frequently caused by *S. aureus,* and is manifested by septic pulmonary emboli initially without signs of valvular involvement. In drug addicts left-sided endocarditis more commonly affects the aortic valve and may be superimposed on previously abnormal or prosthetic valves. It is most frequently caused by *S. viridans,* occasionally by staphylococci, Candida or gram-negative organisms. It may be manifested by systemic emboli as well as fever, sweats, anemia, congestive heart failure and often, but not always, a change in the character of previously present heart murmurs or the onset of a new murmur.

B. Myocardial disease. Myocardial disease is known to occur in association with several agents, the most notable of which are the phenothiazines. Chronic administration of phenothiazines is capable of producing cardiomyopathy severe enough to produce cardiomegaly, biventricular failure, and arrhythmias, which may prove refractory to therapy.[18] Quinine, a known diluent in heroin administration, conceivably can contribute to cardiac dysfunction. Recent studies, such as the two cases of quinine cardiotoxicity described by Lupovich, et al.[16] have suggested that quinine can detrimentally affect the cardiovascular system. In addition, cocaine, alone or in combination with heroin ("speedball"), when administered intravenously in large doses may result in immediate death from cardiac failure due to a direct toxic action on the myocardium.[17] It is possible that these drugs, if used in high enough doses for prolonged periods, might produce, alone or in combination, a "toxic" cardiomyopathy, which may or may not be reversible.

C. Pulse and Blood Pressure Changes. The cardiovascular sequelae of marijuana smoking were recently investigated by Beaconsfield, et al.[19] They demonstrated that marijuana smokers, whose hands were immersed in cold water, had increased limb blood flow concomitantly with a rise in pulse rate, impaired vascular reflex responses, and altered re-

sponses to vasoactive compounds, particularly those influencing adrenergic and autonomic activity. The consequences of these findings were: (1) emergency reflex vascular responses were slowed and (2) premedication with atropine or injections of local anesthetic agents containing epinephrine could cause a dangerously long period of tachycardia. The elevation in limb blood flow (a beta-adrenergic-mediated response) might also explain the decreased breath holding phenomenon observed in scuba divers who have smoked marijuana before a dive.[20] A beta-adrenergic stimulating effect has also been noted in a chronic marijuana user who developed increased heart rate, elevated cardiac output, and decreased peripheral resistance in response to exertion after inhalation of marijuana.[21] In addition to the tachycardia alluded to above, and the minor blood pressure oscillations during acute intoxication, intravenous tetrahydrocannabinol has been shown to cause a profound drop in blood pressure and subsequent reversible, non-oliguric renal failure twelve hours after administration.[22]

Acute hallucinogenic drug crises with LSD, mescaline, amphetamines, and belladonna derivatives are frequently associated with hypertension and tachycardia. Schlant and Nutter[23] documented that the administration of intravenous LSD in moderate dosage in anesthetized dogs produces depression of left ventricular function and contractility together with moderate bradycardia. Amphetamines when administered parenterally, or even orally, have been reported to cause severe hypertension occasionally complicated by cerebrovascular accidents and intracranial hemorrhage has been observed in adults after ingestion of 50 mg of amphetamine.[24, 25] Several deaths have occurred in patients taking amphetamines intravenously over a period of weeks to months. Toxicity has been manifested by toxic hypermetabolic state with subsequent cardiovascular collapse.[25] We have studied one patient who apparently sustained an acute transmural myocardial infarction a few minutes after giving himself intravenous dexedrine and who had normal coronary cineangiograms when studied several years later.

The major cardiovascular side effect of psychotropic drugs is their effect on blood pressure. Administration of phenothiazines to patients who have ingested "street" STP (an alleged hallucinogenic, but in reality an amphetamine) markedly augments its adverse effects and can induce cardiovascular collapse.[26]

Other cardiovascular responses that have been documented in heroin addicts include the following: slight increase in pulse rate during addiction, but marked tachycardia during acute abstinence; a slight rise in blood pressure (usually within the normal range) during addiction, but a 15-30 mg Hg rise during acute abstinence; and preanesthetic medicines may produce bizarre hypotensive reactions secondary to a depressed pressor responsitivity.[27]

D. Cardiac Dysrhythmias and Electrocardiographic Abnormalities. In a recent study of 75 drug abusers,[28] 19 of 34 heroin addicts had at least one electrocardiographic abnormality and all 41 multiple drug abusers had abnormal electrocardiograms, whereas age-matched control tracings were all normal. The most frequently demonstrated abnormalities were conduction, depolarization and repolarization abnormalities, and bradyarrhythmias.

Tachyarrhythmias are frequently observed in persons abusing amphetamines and probably accounts for a majority of sudden deaths noted after large amounts are administered;[26] STP may produce potentially lethal dysrhythmias; surreptitious use of nutmeg has caused multiple atrial and ventricular extrasystoles;[26] bigeminy has been described in d-propoxyphene intoxication;[29] and various cardiac dysrhythmias have been attributed to quinine.

Glue and solvent sniffing is also associated with sudden death presumably due to cardiac dysrhythmias. A recent review[30] reported 110 cases of sudden death during the past decade in American teenage sniffers. Death was usually preceded by a period of hyperactivity or emotional stress. Since no physical abnormalities were found at necropsy, severe cardiac dysrhythmias, intensified by hypercapnia, stress or activity were considered the most likely explanation of sudden death. Dr. Nancy Flowers showed that cardiac dysrhythmias were produced in dogs who were allowed to breathe aerosols propelled with hydrocarbons. The rhythm disturbances consisted mainly of slowing of the sino-atrial pacemaker with resistant junctional or ventricular escape rhythm and ultimate electrical asystole or ventricular fibrillation.[31, 32] After extensive animal experimentation, another report[33] suggested that in humans the cardiac toxicity of aerosol propellants, particularly during asphyxia, may be a cause of sudden death in youths who "turn on" by inhaling propellants. Phenothiazines and other psychotrophic agents often produce electrocardiographic abnormalities.[34] Generally these changes involved the ST segment and the T wave, but several cases of ventricular arrhythmias with sudden death have occurred in association with thioridazine administration.

Vascular Complications

A. Local Thrombophlebitis. Venous obliteration, from scarring induced by repeated injections compromises venous return and causes persistent local edema. Thrombophlebitis of the arms and legs with and without bland pulmonary emboli is commonly

encountered with intravenous drug abuse. Methylphenidate (Ritalin), users are particularly disposed to thrombophlebitis. Septic pulmonary emboli can arise from septic thrombophlebitis. Infected skin, teeth, pelvic and peripheral veins can also give rise to septic pulmonary emboli. In addition, cerebrovascular accidents of acute onset suggestive of embolization have been seen in drug addicts.[35]

B. Local Arterial Occlusion. An addict occasionally injects the drug into an artery, intentionally or accidentally, rather than a vein, and local arterial insufficiency (unilateral decrease in radial and/or brachial pulse), thrombosis, or even a mycotic aneurysm at the site of injection, may ensue. The exact mechanism of vascular injury after intra-arterial injection of parenteral preparations is not known, but it may be the result of chemical damage to the arterial intima.

C. Aneurysms: Traumatic and Mycotic. Several cases of traumatic arterial aneurysms have been described in heroin users. Mycotic aneurysms have also been reported in a drug addict who had a septic endarteritis in an inferior vena cava-renal fistula and in major pulmonary artery branch aneurysms.[36] Occasionally a *mycotic* aneurysm develops in the pulmonary artery secondary to injection of inert material and introduction of organisms.[37] Recently, microaneurysms of the kidney and liver have been described in patients who took *amphetamines* intravenously.[38]

D. Local Arteritis. The inadvertent intra-arterial injection of a suspension of the oral form of pentazocine has been reported to cause arteritis of small arteries and arterioles.[39, 40] Gangrene and even Volkmann's ischemic contracture results from intra-arterial injection of barbituates (especially secobarbital), amphetamines, propoxyphene, promazine hydrochloride and sodium sulfobromophthalein.[39, 41] Recently, cases have been described of gangrene of the extremities after LSD ingestion;[42] whether the gangrene resulted from focal infection or from the vascular effects of LSD is unclear.

E. Embolic Phenomena. The problem of vascular injury after intraarterial injection of oral preparations, is greater than after injection of parenteral agents because of the presence of numerous additives in preparations for oral use. Injection directly into the arterial system may result in embolization of particulate matter to peripheral blood vessels. This, in association with superimposed thrombosis, infection, or foreign body reaction, may cause vascular obstruction in the arterial system at a site distant from injection; particulate embolization has a predominant role in the production of tissue ischemia.

F. Angiothrombotic Pulmonary Hypertension. A relatively uncommon complication of intravenous drug abuse known as angiothrombotic pulmonary hypertension occurs in addicts who repeatedly inject preparations intended for oral use. Oral tablets containing talc or starch fillers, when injected *intravenously,* can cause foreign body granulomas, fibrosis, and arteritis in the lungs and result in pulmonary hypertension. Central nervous system stimulants and antihistamines have been implicated in the development of cor pulmonale. Embolization of the inert filler, when injected, may end up in the pulmonary arterial tree producing arterial, anteriolar, and capillary thrombosis and a granulomatous response in and about the walls of the pulmonary blood vessels. The pulmonary vascular sclerosis is evident on chest x-ray as an interstitial reticulonodular infiltrate. Clinically, this syndrome is manifested by signs and symptoms of pulmonary hypertension, including dyspnea, a pulmonary ejection murmur, and right ventricular hypertrophy; pulmonary function studies indicate a restrictive type of lung disease.[43] The use of "blue velvet," a narcotic mixture consisting of paregoric and ground-up tripelennamine tablets has produced extensive occlusive sclerosis of the pulmonary arterial tree and has resulted in cor pulmonale in addicts in the Detroit area.[44] Similarly, heroin and methadone, adulterated with starch or filtered through cotton, have produced granulomas, thromboses, and obliterative vascular changes causing pulmonary hypertension. The thromboses are due to starch (in oral secobarbital) and/or talc (in tripelennamine).[45]

Methylphenidate hydrochloride tablets, when suspended and injected intravenously, occasionally produce severe pulmonary hypertension which has been fatal to at least four addicts during the past year.[46] The tablet filler (talc or cornstarch) has been found to cause foreign body granulomas in the lungs and heart valves and to become deposited as minute crystals in the liver, spleen, kidney and retina. Talc and cornstarch emboli have been found in the eyes of these drug abusers causing significant visual defects invariably associated with pulmonary granulomatosis and marked pulmonary hypertension.[46] Particulate matter may apparently enter the arterial circulation after passing through the pulmonary capillaries or perhaps a transiently opened foramen ovale in a patient with acute cor pulmonale.

G. Necrotizing Angiitis. Another vascular complication in drug addicts is necrotizing angiitis. Citron, et al.[47] described 14 patients whose presentation with fever, leukocytosis, renal failure, and systemic hypertension was indistinguishable from peri-

arteritis nodosa. Methamphetamine alone or in combination with heroin was commonly used by these patients. In another series of patients, severe gastrointestinal, renal and cardiac involvement, together with impaired visual acuity apparently due to retinal angiitis, was associated with the intravenous use of combinations of methamphetamine (methedrine), and LSD or heroin. Bilateral selective renal arteriograms proved helpful in investigating these lesions.

Danger to the Fetus

Several drugs have been implicated as a cause of congenital heart defects in small percentages of patients. Dr. James J. Nora, who has done extensive research on this subject, has supplied the following information:[48]

> "A model for the way drugs act to produce congenital malformations, including cardiovascular malformations, is provided by experience with dextroamphetamine. In experimental animals, it is clearly a potent teratogen, producing a highly significant increase in cardiovascular and other anomalies which spontaneously occur in low frequency in these animals.[49] In the C57 mouse it produces ventricular septal defect (VSD) in 11.2 per cent of exposed offspring as compared with the 1 per cent spontaneous occurrence of VSD in this strain of mice. In the A/J strain of mouse, dextroamphetamine causes atrial septal defect (ASD) in 13.1 per cent as compared with a spontaneous occurrence of ASD of 1 per cent in this mouse. Thus it appears that dextroamphetamine brings out the malformation 'running in the family' when given at the vulnerable period of cardiac development. In the human similar observations have been made. Dextroamphetamine produces malformations in the human under the conditions of: (1) predisposition to the malformation; (2) predisposition to the teratogenic effects of the drug; and (3) administration of the drug at the vulnerable period of embryogenesis. The frequency of cardiac malformations is increased significantly in patients whose mothers were exposed to dextroamphetamine during early pregnancy.[50] From the dextroamphetamine studies evolved the proposal of the Multifactorial Inheritance Hypothesis for the etiology of congenital heart disease,[51] which in its simplest terms states that it is an interaction between an hereditary predisposition to congenital heart defects and an environmental trigger, such as a drug or a virus, which leads to congenital cardiovascular malformation."
>
> "Congenital heart defects occur in approximately 1 per cent of live births (35,000 per year).[52] An attack on the genetic aspects of the problem will soon be within our scientific capability. But what is within our present capability is the knowledge and skill to identify and remove as risk factors environmental triggers, among them drugs, which are responsible for the production of a significant portion of congenital heart lesions."

Conclusions

The cardiovascular complications of drug abuse are common and serious. The cardiac, venous, and arterial lesions may kill the one who uses a variety of substances. The care of such patients is complex requiring a large number of highly skilled personnel and considerable financial resources. The psychosocial ills that are the forerunner of such behavior must be dealt with in order to prevent the tragic consequences described in this report. ■

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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

June 8, 1974

Appointments: Education Committee—F. Dempsey Guillebeau, Albany. Access to Health Care—Reappointed. Atlanta Area Family Planning Council Steering Committee—Charles Ward, Decatur.

Employee Health Insurance Plan: Authorized a changeover from Atlanta Blue Cross/Blue Shield to Penn Mutual for employees health insurance plan with expanded benefits but at approximately the same cost.

Employee Education Policy: Reaffirmed policy of reimbursement to members of staff for the cost of job-related educational courses.

Ad Valorem Tax: Authorized the hiring of Mr. Larry Evans as an appraiser to represent MAG on property tax assessment.

HMO: Authorized HMO Committee and Legislative Committee to draft HMO legislation consistent with MAG policies and hold such legislation for possible future use.

1975 AMA Clinical Meeting: Directed F. G. Eldridge to investigate group travel possibilities to AMA Clinical Meeting set for Hawaii in 1975.

AMPAC: Endorsed Dan Bateman, Albany, for a seat on the AMPAC Board of Directors.

A case report is presented along with discussion of retrospective experience at the Eugene Talmadge Hospital.

A Simplified Classification for Nonparasitic Cysts of the Liver

LAWRENCE P. DAVIS, M.D., *Augusta**

NONPARASITIC CYSTS of the liver constitute a relatively rare benign condition of the liver.[3] A recent case at the author's hospital prompted a review of the different types of these lesions (Table 1) and their treatment.

Case Report: A 33-year-old white female was admitted for workup of abdominal pain and right upper quadrant mass. Her history revealed that four years prior to this admission she had the insidious onset of right upper quadrant stabbing nonradiating pain. This was associated with intermittent swelling in the right upper quadrant which had increased until the present time. The patient had been hospitalized two weeks prior to admission at our hospital and an upper GI, gallbladder viz, and barium enema were obtained which (with the exception of an incompletely rotated colon) were within normal limits. She denied any hematemasis or hematochezia. On physical examination the patient had a firm, irregular, 15 centimeters in diameter mass in the right upper quadrant with some motion on respiration. The mass was felt to be fixed to the posterior abdominal contents. There were no rubs or bruits. No fluctuance was palpable. During her hospital course a liver-spleen scan showed displacement of the hepatic parenchyma posteriorly. A celiac arteriogram with selective superior and mesenteric arteriograms was performed which showed crossed fused ectopic kidneys on the left. There were no unusual or splayed vessels in the region of the liver mass, however, on the venous phase of the arteriogram an opaque rim outlined a large mass in the right upper quadrant. The patient was subsequently explored through a right upper quadrant transverse incision and was found to have a large single giant cyst of the right lobe of the liver. This was multi-locular and one locule contained cholesterol crystals suggesting a congenital origin. The remainder of the cyst locules contained bilious material.

Hepatic cystectomy was performed in addition to an appendectomy for the abnormal position of the appendix in the right upper quadrant (due to incomplete rotation of the hind gut). Penrose and sump drains were left in place and brought out through a stab wound lateral to the incision. Postoperatively the patient's course was complicated by a urinary tract infection which responded to treatment. There was only a moderate amount of bilious drainage from the penrose drain sites and at the time of discharge a rubber catheter was inserted into the wound for further drainage of bile. This was planned to have been removed at a clinic visit within the ensuing week.

Pathological Diagnosis

Gross description: The specimen consisted of a large thin walled multi-loculated cystic structure measuring 15 x 7 centimeters. The surface had a grey blue color and was mottled in areas. There was also a small amount of yellow fatty tissue attached to the surface. The resected end of the portion had a separate cavity measuring approximately three centimeters across which was lined by yellow grumous type material. A representative section

TABLE I
PROPOSED CLASSIFICATION OF HEPATIC CYSTS

Single	**Simple** **Giant**
Multiple	**Polycystic liver (associated with Polycystic kidneys)** **Multicystic liver**

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through this area was submitted en bloc. There was no gross tissue which was compatible with liver parenchyma along the line of resection. In dissecting through the specimen, the walls of the loculated cyst seemed to be rather thin and have fibrous elastic character to them.

Microscopic Description

The walls of the loculated cyst were made up predominately of collagenous and fibrous tissues with variable amounts of chronic inflammation and hemorrhage. Several sections contained small bands of normal appearing liver parenchyma with intact locular architecture. The liver tissue was completely imbedded within the cystic walls except for a section through the small cavity lined by yellow grumous material at the line of resection. Isolated bile ducts were often seen travelling in cyst walls and sometimes these were quite large in cross sectional areas. Many sections showed the cystic walls to be lined by single cells which varied in shape from cuboidal to tall columnar. Brush borders were commonly seen along this lining epithelium; many cells having subluminal vacuoles. The vacuoles contained a fine grey and bluish material which was most likely cholesterol. Final diagnosis was bile duct cystadenoma.

Nine Cases Discussed

There have been nine nonparasitic cysts of the liver at Eugene Talmadge Hospital from 1967 through 1973. As seen in Table II using the proposed classification three patients had polycystic disease of the liver associated with polycystic kidneys, four had multiple cysts of the liver not associated with renal cysts and two patients had single cysts of the liver. One of the patients in the latter category was the patient in the case presentation, who was diagnosed as cystadenoma, and the other was diagnosed as simple cyst of the liver. The ages of the patients ranged from 6 hours to 67 years but the usual patient was an adult who averaged 52.7 years of age. Females predominated over males in a ratio of 8 to 1, and the cysts seemed to be more common in the patients of the black race. Table III reveals of list of the patients with respective age, race, and sex. It can be seen that pain or mass was the presenting complaint in four out of the nine patients. The first two patients including the newborn were diagnosed as having polycystic liver only after other lab tests or x-rays suggested renal cystic involvement. Patient 4 had multicystic liver found at cholecystectomy and no surgical intervention for the cystic disease was performed.

Table IV summarizes how diagnoses were established or suggested. A liver scan seemed to be the most simple and efficacious way of making the diagnosis. The one patient who had no scan was the black female (patient 4) who had a multicystic liver found serendipitously at cholecystectomy. Exploratory laparotomy or abdominal surgery for other causes confirmed the diagnosis of five patients. Patient 1 who was diagnosed as having polycystic liver from a suggestive liver scan was later explored for a tear in the liver occurring after an attempt was made at hepatic biopsy. No mention of any disease of the liver other than the torn capsule was made on the operative report. Other suggestive x-rays that

TABLE II

SUMMARY OF PATIENTS WITH HEPATIC CYSTS

	Number
Diagnoses	
Polycystic disease of liver associated with polycystic kidneys	3
Multicystic disease of liver	4
Single cysts of liver	2
Ages	
6 hours to 67 years	
Average age—52.71 years	
Standard deviation—11.13 years	
Standard error—4.21 years	
Sex	
Males	1
Females	8
Race	
Black	7
White	2

TABLE III

SYMPTOMS OF EVENTS LEADING TO DIAGNOSIS

1. C. W., BF 52	BSP elevated during admission for other reason; no physical findings	Polycystic liver
2. T. D., BF 6 hours old	Meningomylocele at birth; IVP revealed polycystic kidneys; no physical findings	Polycystic liver
3. L. L., BF 53	Pain RUQ with subsequent mass	Multicystic liver
4. V. C., BF 54	Acute cholelithiasis cysts found at cholecystectomy	Multicystic liver
5. R. N., BF 45	Cirrhosis, masses in upper abdomen	Multicystic liver
6. M. S., BF 67	Cystic mass in epigastrium	Polycystic liver
7. L. D., WM 64	Work up for hypopituitarism	Multicystic liver
8. M. C., WF 34	Mass RUQ with pain	Solitary cyst
9. C. S., BF 58	Mass RUQ with pain	Solitary cyst

Summary
Mass: 4
No Mass: 5

TABLE IV

DIAGNOSTIC TESTS UTILIZED IN DIAGNOSIS

Liver Scan	
Showed multiple defects	**6**
Showed mass defect	**2**
No scan	**1**
Exploratory laparotomy or abdominal surgery	
No mention at laparotomy	**1**
Confirmed at laparotomy	**5**
No laparotomy	**3**
Other suggestive x-rays	
Upper G.I. displacement	**4**
Celiac arteriograms	**3**
Liver function test	**2**
Positive tests associated with:	
1. Patient with hemosiderosis and fatty changes on liver biopsy	
2. Patient previously diagnosed with cirrhosis	

may be helpful would be those showing upper GI displacement, although barium enemas may be helpful if the mass is large enough. Celiac arteriograms only seem to confirm the diagnosis when there is a large mass present by showing no abnormal tumor vasculature. It should be noted that a late venous phase portion of the arteriogram may delineate a thickened capsule of the cyst. The hepatic function tests have not been thought of as helpful in this diagnosis. The two patients who had suggestive liver tests were known to have had previous hepatic disease or pathologic changes were noted on subsequent liver biopsies.

Classification of Cysts

The many types of nonparasitic cysts have been variously classified.[1,2] We propose a classification of these cysts (Table I) into two general classifications: single or multiple. The single category may be broken down into simple cysts which produce no compression clinically or radiographically and giant cysts which are manifest by compression symptoms or a large palpable mass within the abdomen. To qualify as single the cyst must indeed be single or at the most not occur in more than two or three isolated portions of the liver.[4] The multiple category may be thought of as two sub-categories; viz, polycystic liver which is so named because of its association with polycystic kidneys and multicystic liver which is a condition of multiple cysts within the liver not associated with polycystic kidneys. Further classification may include: 1) degenerative or blood cysts; 2) lymphatic cysts; 3) dermoid cysts; 4) epithelial cysts; 5) retention cysts; 6) proliferative cysts such as cystadenomas.[6] These latter categorizations add nothing to the treatment of the lesion; whereas the proposed classification of single versus multiple cysts suggest the potential of surgical extirpation or not, due to associated severe medical problems (polycystic kidneys). Practically all the literature on the latter occur as incidental findings at autopsy.[5]

The treatment of nonparasitic cysts of the liver is basically elective with the exceptions of acute torsion, hemorrhages, or rupture.[6] With single simple cysts the lesion is usually resected. The giant cyst presents a more difficult problem, and if complete excision is impossible, limited resection or marsupilization with internal drainage may be the only surgical procedure. Multicystic disease of the liver not associated with polycystic disease of the kidneys again may present difficulty in complete surgical removal. However, if symptomatic with no associated renal involvement, surgical attack should be planned on an elective basis. Prognosis when polycystic disease of the liver is associated with renal cysts is directly related to the magnitude of the accompanying renal disease. The accepted mortality rate of 5 per cent for surgically treated nonparasitic cysts of the liver may be directly related to surgery on only those patients with accompanying cystic kidneys.[6]

Summary: Nonparasitic cysts of the liver have been vicariously classified by subspecialists on the basis of pathologic or histologic characteristics. These numerous descriptive classifications add nothing to the surgeon's armamentarium except confusion. We propose a simplified breakdown of these lesions based on the relative feasibility of surgical attack.

A case of a giant cyst is presented with subsequent surgical extirpation. This introduces the retrospective experience at the Eugene Talmadge Hospital for the past six years (a total of nine cases). ■

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This rare clinical entity was identified by careful physical examination.

Systemic-Portal Arteriovenous Fistula: A Case Report

THOMAS R. NOLAN, M.D., F.A.C.S., EDGAR D. GRADY, M.D., F.A.C.S. *and*
A. J. CRUMBLEY, M.D., F.A.C.S., *Atlanta**

VAN WAY, ET AL.[1] have recently published an excellent review of reports in the English language of cases of arteriovenous fistulae involving celiac and mesenteric arteries or their branches and the portal venous system, adding four previously unreported cases of their own. Brunner and Stanley[2] have described a post-traumatic case with increased systemic flow. Of the total of 62 cases, 5 were instances where the fistula followed gastrectomy. Because of this relative rarity, the following case is reported.

Case Report

This 52-year-old woman was admitted to South Fulton Hospital on January 11, 1972 because of abdominal pain. Two years previously she had undergone vagotomy and hemigastrectomy for chronic peptic ulcer. Following wound closure, intra-abdominal bleeding required immediate re-operation, at which time a previously clipped bleeding paraesophageal vessel was ligated. Recovery was slow but complete. Six months later the patient had the first of several episodes of rectal bleeding, none massive. About that time she noted the onset of intermittent crampy upper abdominal pain, at intervals of increasing frequency and of increasing severity. Endoscopic and radiographic examination, not including angiography, failed to identify the source. Examination by her physician because of recurrent pain just prior to admission revealed an abdominal bruit, and he referred her for evaluation and treatment. There was no other significant history.

The only significant physical finding was a loud continuous abdominal bruit, best heard in the left epigastrium, with a harsh systolic accentuation. Urine and hematology studies, biochemical profile, ECG, chest and colon x-rays were normal. Radiographs of the stomach and duodenum were normal for her post-gastrectomy status. Liver scan revealed hepatomegaly without splenomegaly.



FIG. 1

The arteriovenous communication is visible. Subsequent selective injection under fluoroscopy identified the afferent vessel as a branch of the celiac artery. Superselective catheterization was not achieved.

Aortic and selective catheter serial angiography (Figure 1) revealed an aneurysmal fistula between a very large artery, apparently a branch of the gastroduodenal artery, and the superior mesenteric vein with immediate opacification of the portal vein. Comparison of gastrointestinal and angiographic films implied that the fistula was just caudal to the greater curvature of the remaining stomach, and probably superficial to the pancreas.

At operation on January 19, 1972, a thrill was

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palpable between the stomach and colon. The fistula was identified in the mesenteric tissues and isolated. Venous pressure was recorded using a water manometer and a No. 22 needle. The aneurysmal dilatation was in the efferent vein, and central to this the pressure was 27 cm. saline with the artery open and 23 cm. saline clamped. Pressure in the portal vein at the porta hepatis was 22 cm. saline with the artery open, 20 cm. saline when clamped. The venous link was a tributary of the superior mesenteric vein which entered the root of the mesentery.

The artery and vein were separately ligated and the fistula removed. Histologic examination revealed an arteriovenous fistula with fibrosis and hyaline degeneration of the arterial and venous walls at the site of the fistula. There was no evidence of foreign material or suture reaction. The first attempt at portal puncture in the porta hepatis was into the common hepatic duct, so a drain was placed at closure. Biliary drainage ceased on the seventh postoperative day. The patient otherwise made a completely uneventful recovery and is well.

Comment

While the sequence of events here suggests a relationship between gastrectomy and fistula, there is no confirmatory evidence. The aneurysmal dilatation was in the vein and ruptured arterial atherosclerotic aneurysm seems unlikely, as does a congenital fistula, though this may be the case.

The hazard of fistula formation due to mass ligature is well documented and preventive effort is widely employed. That fistulae do not occur more often is a tribute to the dedication of surgeons, since the temptation is great. En masse ligation has been decried for generations. Despite faithful adherence to this pragmatic dictum, problems can arise. An estimated 60,000 partial gastrectomies are done in the United States alone each year,[3] and only five previously reported fistulae are known. This situation is therefore rare, and its existence does not imply surgical error. In this case, careful examination by the patient's personal physician led to correction of the hemodynamic abnormality before significant portal-hepatic related pathology arose.

Summary and Conclusions

1. A case of pancreaticoduodenal artery-superior mesenteric vein fistula following gastrectomy for ulcer is described. There is insufficient evidence to establish a causal relationship with certainty, though such a relationship is likely.
2. This entity is rare.
3. Most surgeons are careful and most physicians are diligent. This patient's problem was identified by physical examination, again demonstrating the value of such examination. ■

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GEORGIA HEART OFFERS WORLD-RENOWNED SPEAKERS FOR SEPTEMBER MEETING

More than 500 physicians, nurses, scientists and Heart volunteers, will gather in Atlanta in mid-September for the 26th Annual Meeting and Scientific Sessions of the Georgia Heart Association. The event, which attracts the largest scientific audience in the state each year, will be Friday through Sunday, Sept. 13-15 at Stouffer's Atlanta Inn.

Five world-renowned authorities in heart disease will headline the Scientific Sessions for Physicians, which will also include panel discussions by local heart disease experts.

Featured speakers are Alexander S. Nadas, M.D., chief of the Department of Cardiology at Children's Hospital Medical Center in Boston; Lawrence S. Cohen, M.D., Chief of Cardiology at Yale University School of Medicine; Michael Johnson, M.D., Director of Echocardiography at Duke University Medical Center in Durham;

Denton A. Cooley, M.D., surgeon-in-chief of the Texas Heart Institute in Houston; and Frank C. Spencer, M.D., chairman of the Department of Surgery at New York University School of Medicine.

The program is designed to provide Georgia physicians with in-depth information on the newest techniques in management of surgically correctible heart disease, from the patient's first visit to the physician's office, through diagnostic testing, to modern surgical approaches.

Scientific Sessions for Nurses are scheduled for the same three-day period, with an outstanding faculty which includes Kathleen G. Andreoli, R.N., M.N., of the University of Alabama at Birmingham. Other speakers will be Nanette K. Wenger, M.D., Mark E. Silverman, M.D., Lee Weigel, M.N. and Barry Silverman, M.D., all of Atlanta. Nurses and physicians will meet in joint session to hear Lawrence S. Cohen, M.D.

Georgia Heart Association members will elect officers and present awards at the group's annual luncheon meeting at noon Friday, Sept. 13, just prior to the opening of the Scientific Sessions for Physicians and Nurses.

For registration forms and other information, contact the Georgia Heart Association, 2581 Piedmont Road, Atlanta (404-261-2206).

Comments of the Bibb County Delegation Against PSRO

W. JOHN O'SHAUGHNESSEY, JR., M.D., *Macon**

(Ed. Note: Dr. O'Shaughnessey, president of the Bibb County Medical Society, made the following remarks before Reference Committee C at MAG's Annual Session Business Meeting May 10, 1974 in Savannah, on behalf of his county's delegation. At the request of the U.S. Senate Sub-Committee on Health, chaired by Senator Herman Talmadge of Georgia, a copy of these comments is now in that committee's hands. "It is our feeling that these are extremely pertinent facts which deserve serious consideration in the effort to repeal PSRO," O'Shaughnessey says.)

THE IMMEDIATE QUESTION before this body is whether we should initiate a PSRO in Georgia. Some physicians seem fearful that we would be worse off with a non-professional PSRO than with our own. My opinion and that of the Bibb County Delegation is that physicians should not set up a PSRO for the following reasons.

I have read a lot about PSRO and I have heard a lot of talk by many physicians. But I have yet to hear stated by any MAG physician, even those for PSRO, that they feel PSRO will result in better medical care for Georgians than they now have. I have heard no one say that a PSRO will increase the efficiency of the medical profession itself. In spite of seeing no patient benefits or physician benefits, some will still tell us to set one up.

The Myth of Cost Checking

The stated major objective of PSRO is to reduce hospital costs of Medicare and Medicaid. The major area of cost in the operation of a hospital is in the area of wages for its personnel. In the Medical Center of Central Georgia, our 600 bed non-profit general hospital—I emphasize *non-profit*—the cost of this category has been steadily rising. The single biggest factor causing this rise has been salary changes forced on the hospital by the government's repeatedly increasing the minimum wage. For five consecutive years, beginning in 1967, this minimum wage was increased. Though these wage increases at first were exclusive of hospital personnel, the hospital nevertheless had to repeatedly raise and adjust its salary scale in order to be competitive in the labor pool for personnel who otherwise were being enticed to non-medical jobs by these higher wages.

In 1973, the hospital had 608 fewer admissions than in 1972—resulting in a decrease of 4,685 fewer patient days. Though this drop was due to increased beds being available in other hospitals in the city, for illustration purposes, we could say it was from an effective PSRO. With this drop in admissions, what happened to costs that year? Well, that same year, the cost of salaries went up an additional $667,000 for the same number of personnel. In the next 12 months the hospital salary costs will go up another $500,000 in response to the latest minimum wage increase that became effective May 1, 1974—and the minimum wage is to be increased in 1975 and 1976, thus guaranteeing further escalation regardless of whether admissions go up or down or whether there is a PSRO or not. Does the PSRO law allow protection of hospital costs from minimum wage? *No!* During the same year of 1973 when admissions were down, the cost of food and supplies went up $549,000, entirely due to the inflated cost of these materials, and they are going up this year and next year and every year until inflation is controlled. Does PSRO allow control of the effect of inflation on hospital costs? *No!*

In this country, due to increasing longevity, the number of persons over 65 years of age who are thus eligible for Medicare is rising by 300,000 per year, thus resulting in more Medicare expenditures for hospitalization because more people are covered.

* An internist whose practice is located at 724 Hemlock St., Macon, Ga. 31201.

Will PSRO control this obvious reason for increased cost of Medicare? *No!*

Each year the government—*not physicians*—expands the services provided for these groups of patients. The Supreme Court, for instance, legalized abortion operations. Thus, Medicaid is now funding abortion care. They are now also paying for sterilization operations. They are paying for care by chiropractors and services by private practice physiotherapists. I am not here to argue whether this care is proper or not—I am merely saying that increasing services results in increased costs, and PSRO *cannot* control it.

Lack of Patient Responsibility

Another big problem area of these programs is that there exists no incentive for patient responsibility in the utilization of these programs. In private automobile insurance or in private hospitalization insurance, we practicing physicians find the patient thinks a second time before he acts in a way that results in a claim to the company because he knows he runs the risk of either: (1) having to pay higher premiums; (2) exhausting the benefits of his policy which he may need later; (3) finding himself unable to renew the policy. Is there any incentive of this type for the Medicare patient? *No!* He has a guaranteed renewable policy at unbelievable minimum rates. He pushes the doctor to stay in the hospital longer or to provide him with other treatments or tests because staying in the hospital longer does not cost him any money, does not threaten his insurability, and thus he can lose nothing. The Medicaid patient's responsibility in this program is limited to being sure he does *not* get off welfare. We see welfare patients go to eight or nine doctors with the same minor complaints. Does PSRO induce patient responsibility and incentives to reduce costs? *No!*

Each year the government expands Medicare to more individuals under age 65—such as now the disabled are eligible. This adds huge numbers of people to the Medicare list who will be sending in Medicare bills. Does PSRO control this? *No!* In my home town with a large number of civil service employees, there is a frantic effort by employees near retirement to try to force a medical retirement which, among other things, guarantees that the government will pay the major portion of their health insurance as long as they live. Civil Service Boards are overly sympathetic in granting these medical retirements. Thus, the government pours out more and more money for health care to these people. Does PSRO control this? *No!*

But, gentlemen, there is something about PSRO that bothers us much more than the fact that the medical profession would be involved in helping to organize a government program that is doomed to fail—that will *not* control Medicare and Medicaid costs and will make physicians the scapegoats for its failure.

Called Incompetent, Dishonest

What bothers us most deeply is that this program epitomizes the regard the authors of this program have for the medical profession. They are saying to us that we are incompetent and are dishonest. Because we are incompetent, a guide book must be formulated for medical care so doctors have a written, computerized program to follow and thus are forced to be competent. Because we are dishonest, the law demands the right to enter our offices, to survey our records, to compare treatments, costs and fees.

Personally, we are completely willing to stand any test to determine if we are competent. We will cooperate with any investigation to determine if we are honest. But once we are declared competent and honest, we absolutely refuse to let anything influence the care we render a patient except the medical problem itself or the patient's desires. The medical profession is at this time and probably for all recorded history has been the most respected of all professions. It is respected because nothing has ever been allowed to interfere with the treatment program agreed upon by the doctor and his patient and we refuse to have that agreement warped by the United States Government or anyone who has secondhand information; who has not examined the patient, and who does not carry the medical and legal responsibility for the patient, while exercising his criticism.

We are the now generation of physicians. We will now determine whether the respect for the medical profession in the generation of physicians that follow us will be handed down in the same proud state that we received it. Therefore, this is a matter that is an ethical one and should not be compromised into a political one. We would like to close by reading to you a paragraph from the Principles of Medical Ethics of the Medical Association of Georgia adopted from the American Medical Association Code of Ethics in 1957:

> Section VI: "A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgement and skill or tend to cause the deterioration of the quality of medical care."

Fellow physicians, let us be sure that logic and ethics and not political expediency determine our course of action here today.

Thank you. ■

editorials
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editorials

MAG Leadership Changes Hands

RONALD F. GALLOWAY, Augusta thoracic surgeon, was elected vice speaker of the MAG House of Delegates at the 1974 Annual Session Business Meeting. Dr. Galloway has served the Association in the past as councilor from Richmond County, first vice president from 1969 to 1970, and a member of the Committee on Quackery and Annual Sessions Committee. He is a past president of the Richmond County Medical Society.

The Medical College of Georgia graduate and his wife, Anne, have three children.

Dr. Galloway replaces Leslie Cooper Buchanan who has been elected to the office of speaker of the House. The Decatur surgeon is a graduate of Emory University School of Medicine. He also serves as president of the Georgia Medical Care Foundation and as a member of MAG's Insurance and Economics Committee. His wife is the former Bonnie Mary Turner.

Second Vice President

Second vice president for the coming year will be Atlanta surgeon W. Dan Jordan. He has been active on the PSRO Committee, is chairman of the Private Practice Committee and has served the Medical Association of Atlanta on several committees.

Dr. Jordan was graduated from Emory University School of Medicine with further training at Grady Memorial Hospital. Dr. and Mrs. Jordan (Margaret) have six children and attend St. James Anglican Church in Atlanta.

AMA Delegate and Alternate Delegate

Former MAG Speaker of the House Harrison L. Rogers, Jr., has been elected to the position of AMA delegate, completing the unexpired term of J. Frank Walker followed by an additional full two year term.

Dr. Rogers is in the private practice of surgery in Atlanta. He was graduated from Emory University, completed his internship at Yale and residency at the Boston Veterans Administration Hospital. He has been active with the Fulton County Republican Party and serves as treasurer of the Georgia Chapter of the American College of Surgeons.

Dr. Rogers is chairman of the National Legislative Committee for MAG and past president of the Medical Association of Atlanta. Dr. and Mrs. Rogers have four children and attend the First Presbyterian Church of Atlanta.

J. Dan Bateman of Albany will serve a two year term as delegate to the American Medical Association from January 1975 through December 1977. He has just completed a term as alternate delegate and will be replaced in that position by former MAG president C. Emory Bohler of Brooklet.

Dr. Bateman is a Macon graduate who was educated at the Medical College of Georgia, serving an internship and residency at Charity Hospital of Louisiana at New Orleans. Dr. Bateman serves as a councilor for the Second District, member of the Committee on Quackery and chairman of the Georgia Medical Political Action Committee.

president's letter

Illuminations



WISE MEN HAVE BEEN TEACHING people throughout history by poignant comments. Either by prose or poetry, intuitive thinkers have helped many of us face problems in our own lives, allowing us to see issues more clearly, or solutions more readily. I would like to share some that have meant a great deal to me over the years, with the hope that you will enjoy them and profit from them as I have.

"We have modified our environment so radically that we must now modify ourselves in order to exist in this new environment."

Norbert Weiner

"Some tears belong to us because we are unfortunate; others because we are humane; many because we are mortal. But most are caused by our being unwise."

Leigh Hunt

" . . . just as a single candle cannot illuminate all the dark corners, all the dark corners put together cannot extinguish a single flickering flame."

Dr. Marti-Ibanez

"We are all children of our own age and can never jump over its shadow."

Richard Strauss

"Take what you want from life. Take it—and pay for it!"

Spanish philosopher

" . . . for each age is a dream that is dying,
Or one that is coming to birth."

O'Shaughnessy

"Reality is not the world we look out on, but the world we look out from."

Dr. Charlie Andrews

"All that is gold does not glitter,
Not all those who wander are lost;
The old that is strong does not wither;
Deep roots are not reached by the frost."

Tolkien

"Since I was free to do as I please, I was responsible for what it was that I was pleased to do."

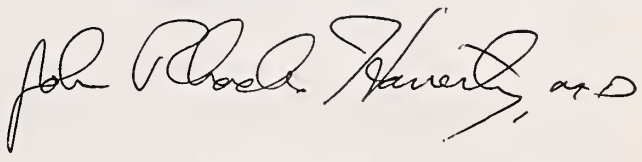
Carl Becker

"Dig it with all speed, dig it,
Thought, you gigantic digger.
Dig a very deep hole, where we can bury
Remembrance of what's over."

Rosalia de Castro

"It is the weak who are cruel; gentleness can only be expected from the strong."

Leo Buscaglia



John Rhodes Haverty, M.D.
President, Medical Association of Georgia

heart page
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heart page

Neonatal Cardiology Centers

WILLIAM B. STRONG, M.D., *Augusta**

In Georgia, the annual incidence of babies born with heart defects is approximately 800. As many as 200 of these babies will require intensive management if they are to survive. It is now within our realm, not only to save, but to potentially cure as many as 60 or 70 per cent of these infants. In very basic dollars and cents terms that means we can enable these infants to reach adulthood and to be productive contributors to our society for many decades.

However, in order to care for these babies, they must first be recognized and identified. There are a few signs which are especially helpful in identifying the infant with heart disease. The signs often are related to respiratory function, therefore, I would like to define the infant at risk as having neonatal cardiorespiratory distress. If an infant with heart disease is distressed in the newborn period, he must be treated as an acute emergency. He cannot be followed until morning or through the weekend.

The signs which should alert the physician caring for babies fall into four major categories: cyanosis, respiratory distress, systemic venous congestion and low cardiac output.

Cyanosis of the extremities may be seen normally in infants who are exposed to a cool environment. Cyanosis of the mucous membranes is always abnormal. Rapid respirations, greater than 60 per minute, in a quiet infant or retractions of the subcostal, intercostal or supraclavicular areas are indications of *respiratory distress. Systemic venous congestion* is manifest by hepatomegaly and/or peripheral edema (most often noted about the face). *Low cardiac output* is evidenced by poor pulses, skin mottling or shock, tachycardia and cardiomegaly.

Note, a heart murmur is not mentioned. Some "benign" defects can cause murmurs while some critical malformations such as transposition of the great arteries may not cause any murmur. Therefore, the decisions about the presence of heart disease should not be based upon the presence or absence of a heart murmur.

Heart disease is only one of the causes of the preceding signs. However, if any one of the signs is present, it should at least raise an "alert flag" as to the possibilities of heart disease.

If heart disease is suspected as the cause of neonatal distress, a call should be placed to your regional neonatal cardiology center where 24-hour teams are available for consultation and/or referral. One of the pediatric cardiologists will be available to help with decision making and arrangements for transportation.

The neonatal cardiology centers in Georgia are located at Henrietta Egleston Hospital in Atlanta, (404) 377-2472, and Talmadge Hospital in Augusta, (404) 724-7111.

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*From the Department of Pediatrics, Section on Pediatric Cardiology of the Medical College of Georgia, Augusta, Ga. 30902. Prepared at the request of the Committee on Physician Education of the Georgia Heart Association.

Amalgamation of Medicine and Osteopathy

SOME COURT SEQUELAE

J. WINSTON HUFF, *Atlanta**

IN RECENT YEARS there has been some trend toward the amalgamation of the practice of medicine and osteopathy. Many states, including Georgia, have by law combined the medical and osteopathic licensing boards and now give the same examination.

Also, the AMA has sought closer contact between doctors of medicine and osteopathy. If local and state medical associations permit, osteopaths may join the local and state societies and thus become eligible for membership in AMA. The AMA has encouraged medical residencies for D.O.s and medical hospitals have been urged to accept osteopaths for staff appointments. Public statements by some AMA officials have given the view that the training and skill of D.O.s is now substantially the same as M.D.s.

This movement toward at least a partial joining of the two professions has produced some unusual court cases.

M.D. Designation

One case arose here in Georgia[1] and was discussed in detail in an article in the June issue of this *Journal.* In this case a federal court held that a practitioner with a D.O. degree could designate himself "M.D." so long as the Composite State Board of Medical Examiners permitted foreign medical graduates who did not have a literal M.D. degree to use the M.D. title. The Board at first requested many foreign medical graduates to return their M.D. licenses in order that they could be reissued a license with the literal abbreviations of their foreign degrees. This understandably caused great alarm among these physicians who had long been practicing under the M.D. designation. The Board then, on its own motion, stayed the reissuance of these licenses. The problem is now being intensively studied by the Board, the Attorney General's office, and by MAG and its counsel. It is hoped that a solution can be found which will comport with the Court's order and at the same time cause the least possible discomfort to the foreign medical graduates affected. It is a difficult problem in the light of the Court's ruling, and may require further legislation which cannot be introduced in the Georgia General Assembly until next year. MAG is keenly aware of the concern of its FMG members and will do whatever it can to correct this situation.

Mixed Background

There have been two other recent interesting cases involving the medico-osteopathic problem. One case[2] was decided in November 1973 by the Court of

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*Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, Atlanta, Ga. 30303.

Appeals of Arizona. Dr. G. W. Ferris graduated from an osteopathic school. Following his graduation he served an internship accredited by the AMA, had a one-year residency in radiology and a six-months residency in pathology, and also had emergency room experience in a St. Louis hospital.

In the state of Arizona the examining boards for medicine and osteopathy are still separate. Dr. Ferris applied to the Arizona State Board of Osteopathic Examiners for a license to practice. He was then advised that the Arizona law governing the licensing of osteopaths requires a one-year internship accredited by the American Osteopathic Association. Since Dr. Ferris' internship and residencies were in medical institutions, the Osteopathic Board refused to grant him a license. Dr. Ferris brought suit to force the Board to give him a license, but the Arizona Court of Appeals upheld the Board's decision. Unless this decision is reversed, Dr. Ferris will not be able to practice osteopathy in Arizona. While the question was not involved in the case, it is reasonable to believe that Dr. Ferris will not be able to get a medical license in Arizona because he attended an osteopathic school. It seems he will just have to go some place else.

Osteopathic Board Phase-Out

The second case[3] was decided in March of this year by the Supreme Court of California. For many years prior to 1962 California had separate examining boards for M.D.s and D.O.s. In 1962 the California legislature adopted a new statute which, in effect, combined the two professions, but in a strange way. This 1962 law took away from the Osteopathic Board the right to examine and license osteopathic graduates. The Board was kept in existence to oversee those D.O.s then currently practicing in the state, with the provision that when the number of osteopaths practicing in the state fell to 40 or less, the Osteopathic Board would go out of existence. The Osteopathic Board was denied the right to issue new licenses, either by reciprocity or examination. Any D.O. who wished could elect to practice as an M.D. in which case jurisdiction over him was automatically transferred to the Medical Board.

The plaintiffs in this case were graduates of out-of-state schools of osteopathy who applied to be licensed in California. When they were turned down they brought suit. The California Supreme Court held that the 1962 California law was unconstitutional. The Court reasoned that, insofar as the new law forbade the licensing of osteopathic graduates regardless of individual qualifications, it operated as a denial of "equal protection of the laws" in violation of both the federal and state constitutions. The Court ordered that these eight osteopaths be allowed to apply and be considered for licensing either as new practitioners or on the basis of reciprocity under the provisions of California law in effect prior to 1962.

We probably have not heard the end of this kind of litigation.

REFERENCES

1. Oliver v. Composite State Board of Medical Examiners, et al, 361 F.Supp. 1262.
2. Arizona Board of Osteopathic Examiners v. Ferris, 514 P.2d 288.
3. D'Amico v. Board of Medical Examiners, 520 P.2d 10.

I've told this before . . . .

(Ed. note: Try to fool a woman and you're tangling with trouble, J. G. McDaniel, M.D. reminds us in his story for July, "The Bull and the Brush Brooms." Others wishing to contribute to this feature page should send their writings to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

The Bull and the Brush Brooms

MANY YEARS AGO THERE WAS a farmer who lived three or four miles from us and owned about 250 acres of land. On his farm were natural springs that formed a lake. To supplement his income, he built a rather crude swimming pool, constructed a few bath houses and charged a small stipend to go swimming.

Unfortunately the swimming season coincided with the farming season and one had to be neglected. In this case, it was the farm and the Johnson grass and Bermuda grass soon took over the fields.

Mr. Buchanan died and his wife moved away to live with relatives and that's how my father came to rent this farm. Old knowledgeable farmers maintained that the only way to get rid of Johnson grass and Bermuda grass in a field was to move off and leave it, especially if it had a head start. But cows will eat it and my father rented it for the taxes, which at that time were very little. He mended the fences and commenced buying yearlings, scrub cows and one or two good bulls.

He made a little money I guess, but his chief enjoyment was pride of ownership . . . he always loved cows.

One beautiful fall afternoon, he decided to walk the fences to determine their state of repair. With a hammer and nails in his pocket, shotgun on his shoulder, he set out. Fortunately very little needed to be done. As his inspection neared its end, he found himself underneath some large oak trees. The ground was littered with the shells of acorns and other signs indicating squirrel country.

It was still an hour by sun, before dark and he dearly loved squirrel pie. He had barely secreted himself before he heard the voices of two women who were coming down a path to the edge of the woods. They were chattering like turkey hens and stopped near a gallberry patch. It soon became apparent that they were going to cut some brush brooms . . . it also became apparent that, with this magpie chatter going on, no sensible squirrel would dare visit the area.

About that time a cow lowed for her calf and this gave him an idea. He hauled off and bellowed like a bull a couple of times in rapid succession. From the gallberry patch he heard, "Lucy, Lucy, be quiet. Did you hear that?"

There was silence and finally Lucy said that she did not, nor could not hear anything. They resumed their chatter, but a little cautiously now as though they were halfway listening, too. About this time he bawled again a couple of times and rattled some leaves and brush as though a bull were pawing the earth.

There was silence and Lucy said, "Louise, I shore heard him then—it's a bull . . . let's get out of here!" They grabbed their cut pieces of brush broom, ran back up the path toward their home, stopping every so often to look back, then take off again.

Two days later, which happened to be Saturday, my father and I went out to check the cows. On the way back these two women were out in their bare front yard, sweeping it with their freshly cut brooms, prettying it up for Sunday. My Dad pulled off the road and stopped in front of their house. They passed the time

of day, discussed the nice fall days, etc., etc., as was the custom then. Then my father got down to the nitty gritty of the stop . . . had they seen a big red bull that he had missed for three or four days?

"Yes, Sah," they replied in unison. "We seed him day before yesterdie right down there in that thar head." And then he asked if they had actually seen him and it turned out that they had heard a big bull stamping his feet and very mad about something and bellowing like he was crazy. My father asked how they could see him from their house. They went on to explain, both talking excitedly, how they were down there cutting these brush brooms and suddenly, etc., etc.

When they had caught their breath he asked how he sounded and they gave a very poor imitation of a bull bellowing. Then my dad said that that did not sound very much like his lost red bull, he went more like this . . . and he bellowed a couple of times.

Lucy looked at Louise in silence and a cloud suddenly lifted from her brow—"Louise, git them brush brooms. I been thinking for two days that that didn't sound like no bull. It wasn't nobody but Mr. Mac."

As they went for their brooms, my father, normally a brave man in adversity, hastily started the car and we drove off.

Down the road, as he was still chuckling, he turned to me and said, "I'm sure glad this old car started right away" . . . and I said, "I am, too!"

J. G. McDaniel, M.D.

TENTH ANNUAL GEORGIA RURAL HEALTH CONFERENCE

Co-sponsored August 28-29, 1974 at the Macon Hilton by the Medical Association of Georgia and the Georgia Farm Bureau Federation in cooperation with the Cooperative Extension Service of the University of Georgia.

WEDNESDAY, AUGUST 28, 1974

Keynote Address—Bond L. Bible, Ph.D., Director, American Medical Association Rural Health Department
"Health Education Within Public Schools"—Jack K. Acree, Executive Secretary, Georgia School Boards Association
"Teenage Pregnancy"—Albert K. Schoenbucher, M.D., Assistant Division Director, Local Affairs, Department of Human Resources
"Nutrition"—Nancy B. Preas, Ph.D., Assistant Director for Home Economics, University of Georgia
"Health Information"—Dorothy Wynn, R.N., Wilcox County Health Access Station

THURSDAY, AUGUST 29, 1974

"Alcoholism"—A. John Mooney, M.D., Statesboro
"Hypertension"—Joseph A. Wilbur, M.D., Georgia Department of Human Resources
"Dental Education"—James B. Hall, D.D.S., Macon

"RURAL HEALTH MEDICAL SERVICES—HOW, WHEN AND WHERE AVAILABLE"

NEW MEMBERS

Becerra, Hernan Clayton-Fayette—Active—FP	2741 Bayard St. East Point, Ga. 30344
Blanc, James S. Cobb—Active—SU	1678 Mulkey Road Austell, Ga 30001
Caswell, Robert J., II Spalding—Active—R	686 S. 8th St. Griffin, Ga. 30223
Collins, Frank B. Muscogee—Active—SU	Medical Arts Bldg. Columbus, Ga. 31901
Eaton, James M., Jr. Muscogee—Active—U	Doctors Bldg. Columbus, Ga. 31901
Fishback, Malcolm E. Richmond—Active—TS	1407-D Gwinnett St. Augusta, Ga. 30902
Mansberger, Arlie R., Jr. Richmond—Active—GE	MCG Augusta, Ga. 30902
Melvin, Perry D. Peach Belt—Active—FP	124 Hospital Dr. Warner Robins, Ga. 31093
Montague, Robert W. Walker-Catoosa-Dade—Active—EM	Tri-County Hospital Ft. Oglethorpe, Ga. 30741
Potitong, Banlu Upson—Active—I	211 Thurston Ave. Thomaston, Ga. 30286
Potitong, Pratoom Upson—Active—PD	211 Thurston Ave. Thomaston, Ga. 30286
Re, Peter K. Cobb—Active—N	50 Plaza Way Marietta, Ga. 30060
Rubin, Joseph W. Richmond—Active—TS	MCG Augusta, Ga. 30902
Simpson, Walter W. Muscogee—Active—EM	Medical Center of Columbus Columbus, Ga. 31901
Still, Joseph M., Jr. Richmond—Active—PL	MCG Augusta, Ga. 30902
Swisterski, K. P. MAA—Active—ANES	20 Linden Ave., N. E. Atlanta, Ga. 30308
Tarrant, Grace L. Bibb—Active—R	Medical Center Macon, Ga. 31201
Townsend, Robert M. Cobb—Active—FP	627 Cherokee St. Marietta, Ga. 30060
Tuten, Carroll S. Glynn—Active—OPH	3011 Kemble Ave. Brunswick, Ga. 31520
Yu, Albert Clayton-Fayette—Active—SU	213-B Arrowhead Blvd. Jonesboro, Ga. 30236
Zakaria, Majed S. Clayton-Fayette—Active—SU	33 S. W. Upper Riverdale Road Riverdale, Ga. 30274

SOCIETIES

Marvin Goldstein, Ph.D., was the featured speaker at the June 17 meeting of the **DeKalb County Medical Society** in a program on the use of hypnosis in medicine.

Muscogee County has completed its annual doubles tennis tournament for members with Lederle trophies being awarded to Walker Harris and Marvyn Cohen who defeated Dan Newberry and Bill Hayes. Second place trophies were presented to Newberry and Hayes by Ross Laboratories.

Teams reaching the quarter finals included A. J. Kravtin and Dick Thompson, Frank Star and Ken Goldman, Dave Varner and John Todd, Henry Boyter and Norman Goldman, Sam Rice and John Van Duyn, and George Zubowicz teamed up with Bob Maughon.

PERSONALS

First District

Robert J. Di Benedetto and **Paul F. Jurgensen** are the authors of "Infectious Mononucleosis Meningoencephalitis," which appeared in the June *Southern Medical Journal*.

Claxton physician, **Curtis Hames,** has been elected to a five-year term as member of the board of trustees of the Medical College of Georgia Foundation, Inc. of Augusta, which is chartered to receive private gifts for the school. Dr. Hames also conducted a district heart workshop in Statesboro in May for volunteers from several counties.

Third District

Richard E. Thompson, Columbus, has resigned his position as chief of pediatrics at the Medical Center to accept a position with the Joint Commission on Accreditation of Hospitals, which is based in Chicago.

Fifth District

Atlantan **J. Harold Harrison** has been elected president of the Medical College of Georgia Foundation, Inc. of Augusta.

William E. Huger, Atlanta, has been elected treasurer of the Southeastern Plastic and Reconstructive Surgery Association.

THE ASSOCIATION / Continued

Sixth District

James L. Achord, Macon, medical director and director of medical education at the Medical Center of Central Georgia, has been elected regional governor for the South Region of the American College of Gastroenterology.

Seventh District

Kennestone Hospital director of medical affairs, **Luther G. Fortson,** Marietta, has resigned to re-enter private practice.

Tenth District

Audrey K. Brown, professor of pediatrics at the Medical College of Georgia, was one of 50 scientists from several countries to present papers at an international symposium in Jerusalem on jaundice in the newborn.

Newly-elected president of the Georgia Society of Dermatologists is **Donald C. Abele,** professor of dermatology and medicine at the Medical College of Georgia.

DEATHS

William Gaston Brawley

Pediatrician William Gaston Brawley, 51, of Avondale Estates, died May 22 following a heart attack.

Dr. Brawley was educated at Emory University and the Medical College of Georgia, and was a member of the associate faculty of the Pediatric Assistantship Program of Georgia State University. He was active in the Greater Atlanta Pedatric Society, Grady Clinical Society, Atlanta Orchid Society and Decatur Presbyterian Church.

Survivors include his widow, Mrs. Dorothy Perry Brawley; daughters, Dorothy Elizabeth Brawley of Avondale Estates and Mrs. Burr E. Strader of Decatur; sons, W. Gaston Brawley, Jr. of Marietta, Bolling Whitfield Brawley and Donald Perry Brawley of Avondale Estates; mother, Mrs. Eloise Gay Brawley of Decatur; brother and sister.

R. Thornton Camp

Fairburn physician R. Thornton Camp, 84, who had practiced medicine in that community from 1913 until his retirement in 1970, died May 23.

Dr. Camp was graduated from Emory University School of Medicine and served in the medical corps during World War I. He was a member of the Fairburn First Baptist Church, where he had served as a Deacon, was a member of Fairburn Lodge No. 180, F & AM, and served on the Board of Directors of the Fairburn Banking Company.

He is survived by his widow, Mrs. Grady Short Camp; sisters, Mrs. Pauline Zwicker, of Denton, Texas, Mrs. Dorothy Sims of Clearwater, Florida, Mrs. Anne Schwettman of Decatur and Mrs. Ruby Henderson of Cumming; grandson, Russel G. Camp; nieces and nephews.

Walter Gus Elliott

Patterson Hospital chief of staff Walter Gus Elliott, 71, of Cuthbert died May 12 following a heart attack.

A native of McDonough, Dr. Elliott graduated from Emory University School of Medicine and served his internship and residency at Grady Memorial Hospital.

He began his practice in Cuthbert in 1928 and served two terms on the city council, in addition to being active as a Rotary club member, Mason, Shriner and member of the Sons of the American Revolution. He was a member of the Cuthbert United Methodist Church.

Dr. Elliott was a director of the Georgia Heart Association, president of the Georgia Chapter, American College of Chest Physicians and president of the Georgia Academy of Family Physicians. He had served as third district councilor for MAG, and was a member of the Southern Railway Surgeons and the Seabord Coastline Railway Surgeons.

His survivors include his widow, Mrs. Clara Belle Elliott; son, William G. Elliott of Valdosta; brother, John Elliott of McDonough; three sisters, Miss Rachel Elliott and Mrs. Susan Steele of McDonough, and Mrs. Travel Lee Wright of Jonesboro; four grandchildren; nieces and nephews.

Charles H. Field

Macon physician Charles H. Field, 58, died May 11. The Medical College of Georgia graduate interned at Vanderbilt University Hospital, where he took his premedical school training. Four years were spent by him in the U.S. Navy.

Dr. Field was in the private practice of neurology and neurosurgery and was a member of the Georgia Neurosurgical Society. He was a member of the American Legion, Idle Hour Country Club and the Moose Club in Macon.

Survivors include his widow; Mrs. Helen Minges Field of Macon; three sons, Charles Wayne Field of Marietta, Hyatt Minges Field of Athens and Robert Setzer Field of Macon; brother, Fetner Field of Macon; sister, Mrs. Charles Nelson Fowler of Macon.

Thomas E. Fulghum

Thomas E. Fulghum, district director of health for the Northwest Health District, died March 29 at the age of 59 in Hamilton Memorial Hospital following a heart attack.

A naive of Augusta, Dr. Fulghum attended Augusta College and the Medical College of Georgia. His internship was completed at Piedmont Hospital in Atlanta and his residency in eye, ear, nose and throat at Griffith Hospital in Atlanta. Military duty in the U.S. Army and U.S. Navy was completed in 1946, following which Dr. Fulghum was in private practice in Augusta and medical director of Tidewater Hospital.

He had served as a district health director since 1963 and received his masters of public health in 1966 from the University of North Carolina. He served as president of the Georgia Association of Local Public Health Physicians from 1969-1970 and had assisted the Northwest Georgia Boy Scouts of America by working as medical advisor.

Survivors include his widow, Mrs. Mary Powell Fulghum; three sons, Baird Fulghum of Athens, Jim and Keith Fulghum of Dalton; mother, Mrs. Lula Fulghum of Dalton.

Harvey E. Griggs

General practitioner and four time mayor of Conyers.

Harvey E. Griggs, 72, died April 22 in Rockdale County Hospital.

Dr. Griggs was born in LaGrange and graduated from Maryville College in Tennessee. He completed requirements for his M.D. degree in 1928 from Emory University School of Medicine and interned at Grady Memorial Hospital.

After serving as a doctor for several coal mines in Kentucky Dr. Griggs began his practice in Conyers in the early 1930's. Dr. Griggs received the Selective Service Medal after serving as medical examiner during World War II. He was a deacon of the Conyers First Baptist Church, charter member of the Conyers Lions Club, member of the school board and a Mason.

Mrs. Frances Griggs, his widow, survives him. Other survivors include his daughter, Mrs. A. B. Foster; two granddaughters; sisters, Mrs. Frank G. Beall and Miss Minnie Griggs of Evarts, Ky.

Fredric Rudy Minnich

Fredric Rudy Minnich, Atlanta physician, died May 19 following a heart attack. Dr. Minnich served on the staff of Piedmont Hospital and the faculty of Emory University School of Medicine. He was a member of the Board of Obstetrics and Gynecology, the Atlanta Gynecology Society, the Piedmont Driving Club and Capital City Club.

He is survived by his son, Fredric C. Minnich of Atlanta; daughters, Miss Maryann Minnich of Atlanta and Mrs. John T. McNeil of Thomson; brother, Dr. William R. Minnich of Atlanta.

H. E. Mitzelfelt

Blue Ridge physician H. E. Mitzelfelt died April 24 in Watkins Memorial Hospital at the age of 65.

The Illinois native had practiced in Gilmer and Fannin Counties for several years and served as secretary of the Blue Ridge County Society for MAG.

Survivors include his widow; Mrs. H. E. Mitzelfelt; two daughters, Mrs. Patricia Silvers of Macon, Fla. and Mrs. Silva Eddings of Nashville, Tenn.; two sons, Dr. Harold Mitzelfelt of Los Angeles, Calif. and Richard Mitzelfelt of Farmington, N.M.; 10 grandchildren three sisters; two brothers.

W. Loyd Osteen

Savannah anesthesiologist W. Loyd Osteen, 56, died May 15 at St. Joseph's Hospital following a long illness.

Dr. Osteen was born in Pembroke and educated at the University of Mississippi and the Medical College of Georgia, and Oxford College in England. He was a veteran of World War II and received a bronze star for his service.

Dr. Osteen was one of the first anesthesiologists in the Southeast when he began practice in Savannah in 1945. The creation of an intensive care unit at St. Joseph's, for which he was chief of the anesthesiology department, and a blood bank for Savannah were projects of Dr. Osteen.

Active in Wesley Monumental United Methodist Church, Dr. Osteen served as Steward and Sunday School teacher.

Survivors include his widow, Mrs. Elaine Goodson Osteen; son, Dr. Robert T. Osteen of Brookline, Mass.; daughter, Mrs. W. H. Norman, III of Tuscaloosa, Ala.; father, T. T. Osteen of Pembroke; three brothers, Dr. A. J. Osteen of Camilla, Dr. Oswald L. Osteen of Beltsville, Md. and Gen. (Ret.) W. Marshall Osteen of Pembroke; granddaughter; nieces and nephews.

James Roscoe Sams

Newton County physician James Roscoe Sams, 84, died May 1 at Emory University Hospital in Atlanta.

The Newborn native received his M.D. degree at the Medical College of Georgia in 1912 and interned at University Hospital in Augusta. After serving as a battalion surgeon in World War I, Dr. Sams entered private practice in Covington. He was a charter member and past president of the Covington Kiwanis Club; charter member of the Newton County Historical Society; member and steward of the First Methodist Church; past commander of the American Legion. For several years he served on the Newton County School Board and was president of Newton Federal Savings and Loan Association.

He is survived by his daughter, Mrs. Lewis Thompson of Covington; sister, Mrs. L. J. Pharr of Newborn; half-sister, Mrs. Doyle Mitchell of Decatur; two brothers, Lewis Reeve Sams of Gainesville and Marion Sams of High Point, N.C.; three grandchildren and two great-grandchildren.

Hart Sylvester

Fifty-two-year-old Hart Sylvester of Hawkinsville died April 28 following a brief illness.

A graduate of South West Louisiana University and Tulane University, Dr. Sylvester served as a member of the Board of Directors of the Columbus Blue Cross and Blue Shield, was past president of the Ocmulgee Medical Society and former chief of staff for Taylor Memorial Hospital. He was a member of the Hawkinsville First Baptist Church and Rotary Club.

Dr. Sylvester is survived by his widow, Mrs. Doris G. Sylvester; three sons, Chuck, Jim and Tom Sylvester of Hawkinsville; two daughters, Miss Joy and Miss Cathy Sylvester of Hawkinsville; three brothers and five sisters.

The Month in Washington

With the exception of a possible last-minute catastrophic bill to the liking of both the Senate and the House, the prospects for a national health insurance (NHI) bill this year appear to be fading. Preoccupied with the possible impeachment, plus other matters, the pace of House and Senate hearings on NHI has definitely slowed, despite a strong desire on the part of both Republicans and Democrats to take a widely popular health measure with them to the polls this November.

Its late April testimony on NHI before the House Ways and Means Committee behind it, the American Medical Association again advanced its Medicredit proposal for NHI before the Senate Finance Committee at the end of May.

Support for Medicredit

Senate Finance Committee chairman Russell Long (D., La.), and other committee members heard AMA president Russell Roth, M.D., president-elect Malcolm Todd, M.D., and Ernest Livingstone, M.D., chairman of the AMA Legislative Council, support the Medicredit measure.

"As the nations' largest association of actively practicing physicians, the ones who will be called upon to provide the professional services which are contemplated under any program which may be authorized by Congress, we feel that our viewpoints are extraordinarily important," Dr Roth told the committee.

"If we are to meet the principal needs not only of the aged and the poor but of the vast middle income group, it would seem we must endeavor to provide basic coverage for medical service and, if possible, add to this protection against ruinous catastrophic major medical expense (Senators Long and Abraham Ribicoff (D., Conn.) are sponsors of a catastrophic-only type NHI proposal).

"We appreciate the economies of providing only catastrophic coverage, but feel that it will meet too few of the needs and will prove very difficult to administer. We appreciate the appeal of first dollar coverage but recognize the inordinate expense involved.

"The catastrophic coverage should be adjusted to ability to pay, since it is obvious that an amount which could be easy for the well-to-do family to pay could be disastrous for the much larger group of middle and low-income individuals. If the insurance is really to protect, it must be operative at the level of need.

"If I provide $10 worth of service for my patient and he pays me directly, I have earned $10 and he has spent $10. If, instead, money is to be collected from the patient as a tax to be transmitted to Washington, processed, transferred to another agency, processed, passed on to an intermediary, processed, and paid out as a benefit, and then reviewed for appropriateness, I will need to leave it to others to estimate how much more must be collected from the patient to yield the $10 necessary to cover the service rendered. Each complicating step in the process contributes to a shrinkage in service purchased by the medical dollar.

"We believe that the public will look with dismay on a financing mechanism which increases the Social Security tax by 4 per cent, as with the Kennedy-Mills proposal.

"We have enthusiasm for the financing mechanism in the Medicredit bill which uses tax credits to minimize the number of dollars making a round trip to Washington as tax to return as a shrunken benefit, and which places the obligation to contribute their share on those who have the ability to pay all or part of their premium cost. It uses an existing governmental collection agency, minimizes new demands for an increase in bureaucracy, and reduces administrative costs.

"Finally, there is the matter of administering the program. There is precious little evidence that any particular economy or efficiency results from government health programs, but a growing body that the opposite may be true.

"In the case of National Health Insurance, we feel assured that if any part of the funding derives from Social Security taxes there would be a compulsion for Social Security control of the program.

"We are confident that the administration of the program will best be accomplished by existing private entities in the field. Federal involvement, while inescapable when dealing with federal tax dollars, should be kept minimal.

"We again believe that our Medicredit program fulfills these objectives in respect to administration more aptly than does any other proposal to date. We believe the public, in opinion poll after poll, has reiterated its high degree of confidence in the medical profession and its low esteem for bureaucratic administration. We believe that there is validity in other current public opinion polls which indicate that the chief national concern is over inflation," Dr. Roth concluded.

After Dr. Roth had read the statement, Chairman Long said he agreed with the many things that were said by the AMA official, especially the concern about wastage of funds that are channeled through Washington.

Long asked about the merits of a tax credit as opposed to a payroll tax. Dr. Roth said the tax credit is the most equitable in that it relies on the federal income tax which provides an accurate gauge of family income. The money retained by the individual for health insurance does not "have to make the round trip to Washington."

Weinberger Testifies

First witness before the Senate Finance Committee hearing was Health, Education, and Welfare Secretary Caspar Weinberger who urged that a NHI bill "should be the highest priority item in the closing months of this Congress." He expressed hope that the areas of disagreement between competing NHI proposals would not be found insurmountable.

The Secretary, however, criticized all of the competing proposals, but with special attention to the Mills-Kennedy and the Health Security bill of organized labor. "Both vest too much power with the federal government," Weinberger said.

At the sometimes stormy meeting, Senator Vance Hartke (D., Ind.) and Senator Clifford Hansen (R., Wyo.) chided the Secretary for criticizing the AMA plan, pointing out that Medicredit had powerful backing.

Sen. Hansen said that when negotiating time arrives there should be strong consideration of the Medicredit bill which has 182 sponsors, including five members of the Finance Committee and 11 members of the House Ways and Means Committee.

Hansen said the Council of Economic Advisors, and the Brookings Institute have recommended the tax credit method of financing employed by Medicredit should be used in broad federal programs. Weinberger said he preferred tax credits to a Social Security payroll tax, but thought general revenue financing was best. Hansen said controls could impede productivity and cause personnel to leave the health system.

Sen. Hartke said Medicredit has more sponsors than all other NHI bills combined. Weinberger said he would keep that in mind while conferring with Congress. "You are going to have to deal with 182 of us somewhere along the line," Hartke said. "Not just 'President' Kennedy or 'President' Mills."

Hartke said that despite Weinberger's criticism of Medicredit the fact is that all NHI bills basically deal with financing, including the Administration's plan which doesn't provide anything concrete about changing the system.

Sen. Abraham Ribicoff (D., Conn.), said the Administration was being deceptive about the true costs of its program. He contended Weinberger is telling the American people they will have a $55 billion "free lunch."

"You are dealing with the most complex social and economic program in the history of our nation," Ribicoff said. If all sides can't agree to work out a compromise there will be no program."

Senator Long added that Americans must be given all of the facts about exactly what a NHI bill would cost them, pointing out that he couldn't ". . . see a free lunch in any of them."

NHI Hearings

Meanwhile, on the House side the Ways and Means Committee completed the second month of one-day-a-week hearings on NHI.

It would appear that almost every health related organization in the country wishes to be heard. For example, one day's hearing saw the following organizations testify before the powerful House Committee: Blue Cross Association, National Medical Association, American Osteopathic Society, National Council of Health Services, American Podiatry Association, National Council of Community Health Centers, Veterans of Foreign Wars, and Americans for Democratic Action.

Some sparks flew when Andrew Biemiller, director of the AFL-CIO's Department of Legislation, appeared in place of AFL-CIO president George Meany. Biemiller in effect took an all-or-nothing approach, insisting that unless a bill similar to the original Kennedy-Griffiths measure is approved it would be better to wait until next year.

Of major interest to most Capitol Hill watchers is the fact that House Ways and Means Committee chairman Wilbur Mills (D., Ark.), co-sponsor of the Kennedy-Mills proposal, attended the first hearing, but has missed all the rest.

The Position of Labor

Labor's stand drew criticism from committee members, some of whom stressed a theme that there is strong pressure for Congress to act this year especially on a catastrophic bill.

Biemiller said "if Mills-Kennedy is this committee's idea of a compromise, then I must say, in all candor, we will oppose it." Labor's strongest criticism came on the Long-Ribicoff bill. "It is not national health insurance, and does not pretend to be. It would be therefore a catastrophe if the Congress enacted catastrophic insurance," said Biemiller.

Rep. Omar Burleson (D., Texas), told Biemiller that "you are not really willing to compromise at all." He said labor expects a Congress of a "different nature" next year so that it can get all that it wants.

Biemiller replied that the elections of 1964 changed a lot of minds in Congress about Medicare and resulted in its passage in 1965.

Congressional backers of the Medicredit national health insurance plan rallied on the floor of the House of Representatives in early May to praise the NHI approach developed by the AMA.

A score of speakers rose to urge congressmen and senators to join them in backing Medicredit, which has more sponsors—182—than all other NHI proposals combined.

"One reason why the legislation has such support in the Congress is because it is based on some solid principles that are both realistic and workable," declared Rep. Omar Burleson (D., Texas).

Rep. Richard Fulton (D., Tenn.), principal co-sponsor and, like Burleson, a member of the key House Ways and Means committee, told the House that "Medicredit's benefits are comprehensive; its ability to meet our present needs seem unarguable; its price tag in terms of new tax dollars seems to be within the nation's means, and the method it proposes for financing the plan appears to me to rest fairly on the taxpayer without overburdening our Social Security system."

Rep. Joel Broyhill (R., Va.), chief GOP sponsor and a high-ranking member of the Ways and Means panel, said 182 members of Congress "have seen through the fog of rhetoric and printed word swirling about national health insurance. They have chosen Medicredit. I invite more of you to come aboard in support of a sensible piece of legislation."

Broyhill said Medicredit enjoys two prime virtues—free choice of health care setting and physician, and "the American philosophy of voluntarism."

Rep. Tim Lee Carter, M.D., a Kentucky Republican said no other NHI proposal offers as liberal a psychiatric benefit as Medicredit.

The American Psychiatric Association had pointed out that Medicredit stands alone in this regard. "All other NHI proposals contain some discrimination that separates treatment of the mentally ill from that of the physically ill," noted Dr. Carter.

"Medicredit is a workable approach. The medical profession and the public want a plan that keeps the federal government's role at a minimum. From the

standpoint of benefits, efficiency, financing and acceptability, I am convinced that the Medicredit approach is by far the best we have before us," Carter siad.

Rep. Jerry Pettis (R., Calif.), a member of Ways and Means said his colleagues should consider foreign national health systems:

He cited such cases as:

- In Sweden the per capita health care costs increased by 614 per cent from 1950 to 1966 compared to 174 per cent in the United States. Since 1960 medical costs in Sweden have increased almost 900 per cent.
- In West Germany there is a serious maldistribution of medical personnel.
- Norway reports a shortage of practitioners.
- Hospital rates in Canada are higher and length of stay longer than in the U. S.

Pettis said we had better be very careful about tinkering with our present system. "Certainly there is clear warning in these facts to all of us that we should not abandon the strengths of the American system for the type of health delivery system which has been developed in some other country."

Rep. Peter Kyros (D., Maine) said Medicredit "goes right to the heart of the catastrophic problem." "No matter how large or small a family's income, its medical expenses would never exceed 10 per cent of that income," said Kyros. "This would be a tremendous reassurance to every family. At the same time, it offers a fair method—a sliding scale—for sharing the country's major health costs."

Rep. Robert Michel (R., Ill.) said Medicredit "meets the true test of any workable national health insurance plan—it provides access to high quality medical care to all Americans on the basis of sharing the cost in an equitable fashion. The poor would pay nothing. In a fair way, the better-off would pay on a sliding scale that reflected their income."

"Most importantly, this legislation would insure that no American would have to go bankrupt because of a catastrophic illness," said Michel.

Bad Start for PSRO

The Professional Standards Review Organization (PSRO) program is off to "an incredibly bad start" and encountering increasing physician resistance, the American Medical Association has told Congress.

AMA President Russell Roth, M.D., testifying before the Senate Finance subcommittee on health, said 13 state medical societies have formally declared for repeal of the PSRO law and that 29 societies support a policy of amendment and/or repeal. (As of May 7, 1974.)

"We cannot be precise in numbers, but it seems evident that, as understanding of the PSRO law spreads, the resistance to it grows," said Dr. Roth.

The health subcommittee, chaired by Sen. Eugene Talmadge (D., Ga.) slated two days of hearings on the spreading controversy over the PSRO law.

Dr. Roth said "the best efforts of the legislators involved, the staff of the Senate Finance Committee, the staff of the PSRO administrative office in HEW, and physicians from AMA, from assorted state medical societies and specialty medical organizations, have not succeeded in creating in the profession the climate of acceptance and cooperation essential to success. The fault does not lie with the sincerity or intensity of the effort to cooperate, it lies with the basic ineptitudes of the statute."

The AMA President said it has been seriously proposed that because of the bad start on PSRO it may be best to fall back, regroup, and start over again. The official AMA position, he noted, is that repeal may need to be considered if amendatory patchwork is unacceptable.

Robert Hunter, M.D., chairman of the AMA special advisory committee on PSRO and a member of the AMA board of trustees, described to the senators the AMA's extensive "constructive efforts" to cooperate with Congress and the government to make PSRO work.

Edgar T. Beddingfield, Jr., M.D., vice chairman of the AMA's council on legislation, said "the PSRO law has created a great deal of confusion and misunderstanding."

Sections on norms of health care services are patiently contradictory and we would anticipate that the net results would be that the norms of care would be viewed as rigid federal minimum requirements, Dr. Beddingfield said. "Patients and the profession alike are legitimately concerned with the prospect of cookbook medicine." He recommended that the "norms" should be guides for care and should be clearly understood to be initial points of evaluation and review. Furthermore, Dr. Beddingfield said, such guides must not be substituted for the medical judgment of individual physicians in the delivery of health care services.

During the two days of hearings, some 20 medical associations, state societies, and specialty groups testified their general misgivings with respect to the workability of the statute. Throughout the hearings Senator Wallace Bennett (R., Utah) stoutly defended PSRO—"I won't live long enough to see repeal of PSRO"—against, at times, shouting and hostile witnesses. ■

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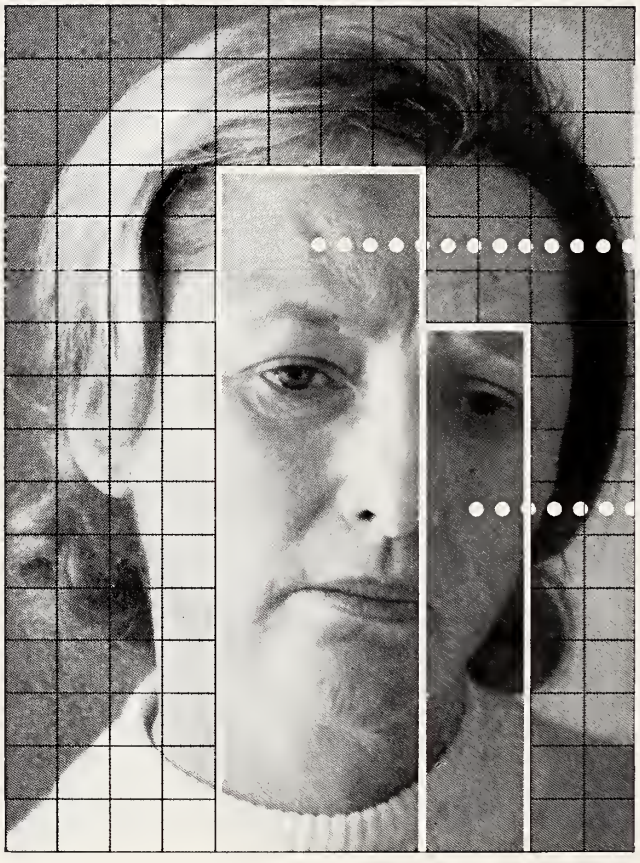


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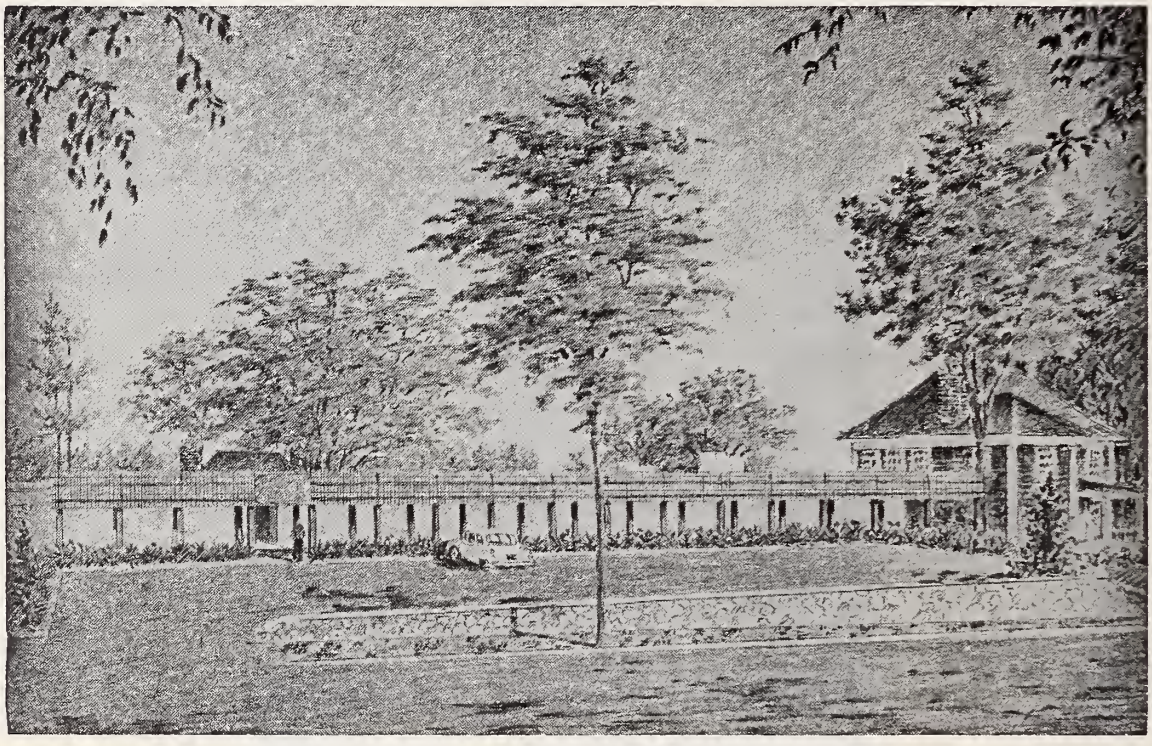
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Sterilization of the Mentally Retarded at the Medical College of Georgia, Under Law No. 1288

VIRGINIA P. MCNAMARA, M.D., WILLIAM A. SCOGGIN, M.D., *and*
FRED RASKIN, J.D., *Augusta and Louisville**

The Georgia Voluntary Sterilization Act (1970) is a carefully worded law written with a view toward protecting the rights of the individual and the interest of society as well. There are three sections within the law; the first two deal with sterilization of the mentally competent; the last, or Section III, with the sterilization of the mentally retarded or brain damaged. This paper will relate to the persons covered in Section III. The two laws preceding the 1970 law will be reviewed but the primary purpose of the paper is to review for physicians, lawyers, social workers and staff of all agencies the experience of the Medical College of Georgia in those cases that have been done under the new law.

Recently, nationwide attention was directed toward the Alabama case in which two girls, allegedly mentally retarded, were sterilized. They later contended that they did not have (to use the Georgia wording) "prior to or at the time of sterilization, a full and reasonable medical explanation by the physician as to the meaning and consequence of such operation, namely, the inability to conceive or reproduce children." A furor over the Alabama case erupted. The Department of Health, Education and Welfare entered the picture inasmuch as the two young Relf sisters were welfare recipients and the sterilization procedure was financed out of federal funds. Dr. Caspar Weinberger, the Director of DHEW, reviewed the situation and expressed concern that the "rights" of the individual in this situation may have been disregarded. After looking into the case, guidelines were devised to be published in the *Federal Register* for one month. The guidelines require that a committee of six be set up to review the merits of every case. This committee cannot have on it any member of the project or organization requesting sterilization. After review, the case then goes to the appropriate court (Ordinary or Juvenile) where the various legal prerequisites in a given state are to be met.

In Georgia, The Committee on Abortion, Sterilization and Family Planning of the Georgia State OB-GYN Society, sent a very strongly worded letter to DHEW, pointing out the excellence of the Georgia law and its explicit wording to protect the "rights of the individual."

At the present time, the federal situation remains unchanged and funds are not currently available for payment of the sterilization procedure on welfare recipients. In this state, and some of our sister southern states with good legislation, the matter is at a stalemate; resolution does not appear imminent. At the Medical College of Georgia, the Chairman of the Department of Obstetrics and Gynecology is currently negotiating with the administrators of this state operated hospital (Eugene Talmadge Memorial Hospital) to learn whether the hospital can absorb the physician and hospitalization costs. For the mentally retarded and the minors in other hospitals, the situation is dismal; without medicaid funds, there will be a stop in the sterilization procedures of the medically indigent.

All who have become involved in the steriliza-

* Dr. McNamara serves as assistant professor, and Dr. Scoggin as professor and chairman of the Department of Obstetrics and Gynecology of the Medical College of Georgia, Augusta, Ga. 30902. Mr. Raskin is a Louisville attorney.

tion program agree that sterilization is a medical matter. If lay committees are formed, one wonders at the adequacy of non-professionals to make decisions of this nature and one becomes even more troubled at the time honored principle of patient-doctor confidentiality. The next few months may see much hue and outcry over these issues.

Rights of the Individual

The explicit wording of the Georgia law would make the Alabama incident an impossible occurrence here. The *finding of need* specifically defines the person subject to the law. The *prerequisites* are clearly defined. The rights of the individual to be represented by a lawyer or guardian ad litem and the mandate for this (if the parent be mentally incompetent or cannot be found, or there is no guardian) are written into the law. The law also provides for the person to contest the decision of the Judge of the Ordinary with an appeal to the Superior Court with a trial by jury. Under Section VI, page 687, the intent, the *protection* of the individual, is reflected with the wording: "The person alleged to be subject to the provision of this section shall have the right to counsel at all stages of the proceedings provided for herein."

Legislation in Nearby States

The laws of the neighboring states of Alabama, Florida, South Carolina and North Carolina are herein discussed to point out similarities and dissimilarities in the laws.

Alabama: On inquiring about sterilization of the retarded laws, we were informed that "there is no law in regard to human sterilization."

Florida: Search of the health laws reveals no law in regard to sterilization of the minor and the mentally retarded.

South Carolina: The State of South Carolina Health Code states: "Whenever the superintendent or any other person in charge of any penal or charitable institution of this State shall be of the opinion that it is for the best interest of the inmates of the institution of which he is superintendent or in charge that any inmate of such institution who is afflicted with any hereditary form of insanity that is recurrent, idiocy, imbecility, feeble-mindedness or epilepsy should be sexually sterilized, such superintendent or other person in charge shall present to the executive committee of the State Board of Health a written petition stating the facts of the case, and the grounds of his opinion, verified by his affidavit to the best of his knowledge and belief, and praying that an order may be entered by the committee authorizing him to perform or have performed by some competent physician or surgeon to be designated by him in his petition or by the committee in its order upon such inmate named in such petition, at one of the institutions of the State." (Article 7, page 325, 32-671)

The South Carolina law is almost identical to the 1937 Georgia law that was superseded by the Voluntary Sterilization Law of 1970. Unfortunately, at this time in South Carolina, there is no legal provision for sterilization of the non-institutionalized individual; furthermore, the requirement that the patient have a hereditary form of insanity makes the law very unwieldy and difficult.

North Carolina: The North Carolina law is similar to the Georgia law except the mentally retarded or the minor is within the jurisdiction of the Juvenile Court and the order to perform sterilization must be posted 30 days in excess of the actual performance of the surgery.

The Georgia Law

Until the Voluntary Sterilization Law of 1970 was passed, there was no workable legal provision for sterilization of the retarded. The present law not only includes provision for the unmarried, if of legal age, but the married of any age and *most importantly* for the sterilization of the mentally retarded and the brain damaged. The current law abolishes the State Board of Eugenics created by the 1937 law and repeals the 1966 law in entirety. Though titled "Voluntary Sterilization Law" in Section III, the law spells out specifically procedures necessary for sterilization of the mentally incompetent.

Mentally Retarded, Brain Damaged

Section III of this law defines a person subject to sterilization as follows: "A person, whether or not twenty-one (21) years of age, who because of mental retardation or brain damage or both, is irreversibly and incurably mentally incompetent, to the degree, that such person, with or without economic aid (charitable or otherwise) from others, could not provide care and support for one or more children, procreated by such persons in such a way, that such children could be reasonably expected to survive to the age of twenty-one (21) years, without suffering or sustaining serious mental or physical harm."

The prerequisites for documenting the retardation and obtaining a court order for sterilization have been put into the law, however, for clarity and ease of answering inquiries addressed to MCG, these steps have been abstracted and listed as follows:

I. Parent or guardian must sign permit giving permission for surgical procedure.

II. Form No. 1 is presented to the Ordinary in the county of residence.
The petitioner may be one of the following:
A. Parent, guardian or next of kin
B. Chairman, State Board of Health; Director, County Board of Health
C. Director, State Department of Family and Children Services
Director, County Department of Family and Children Services

III. The Ordinary appoints two physicians in the county to examine the patient and report to the court (Form No. 2) whether the patient has a condition requiring her sterilization.

IV. Patient is tested to document her retardation by a psychologist or a psychometrist.

V. Three M.D.s of the medical staff of the accredited hospital in which the operation is to be performed must sign a form (form No. 3) saying they have examined the patient and concur that she has an irreversible and incurable condition and requires sterilization. The M.D. performing the surgery cannot be one of the three signing physicians.

VI. The Ordinary of the county then reviews the evidence and authorizes an order to the physician to perform the sterilization procedure (form No. 4).

It will be noted that there is no instruction in this list for the provision of a lawyer or guardian ad litem to represent the patient. The Attorney General ruled that the provision is mandatory only when the parent is mentally incompetent or cannot be found or there is no guardian to sign the permission within the original petition. The Judge of the Ordinary, if he wishes, may appoint a lawyer for the girl, even if there be a competent parent. The intent of the law may be that if the patient does not wish to be sterilized, *then* she is entitled by law to an appeal and must have legal representation, court appointed (if she does not secure legal representation independently). In our experience, some Judges of the Ordinary required a lawyer for every mentally incompetent person; some do not require legal representation unless the parents are mentally incompetent or deceased.

The explanation to a girl with an I.Q. of 45 that she could not become pregnant would be an explanation she could not understand; however, the physician must make sure the parent or guardian understands the finality and irreversibility of the sterilization procedure. It has been our practice to sterilize only the moderately and severely retarded, not the borderline retarded. Here again, in addition to psychometric test results, a subjective judgment must be made.

In the early phase of the program, it was necessary to become familiar with the wording and the intent of the law, and to develop forms, procedures, and working relationships with many Judges of the Courts of Ordinary. In each county, the first case required a meeting of the legal and medical minds to insure that the provisions of the law were being interpreted accurately and even more significantly, that the rights of the individual were being protected.

Early Problem Cases

Not every case proceeded smoothly. Occasionally, the religious beliefs of the individuals involved would threaten to delay proceedings, but in every instance the issues were resolved to the satisfaction of all.

In one county, there did develop an impasse of a different sort and it still stands. In this case, involving a severely retarded mother of three, the patient's mother objected to the necessity of a trip to the courthouse and the guardian ad litem felt such a trip was necessary. In the most recent efforts at follow-up, the patient had disappeared to a distant state. There are unfortunately a few people who have known the local courthouse as a place of punishment and not of help and succor.

In another unfortunate experience an attorney, when consulted by the parents of a retarded girl (who also has a genetically transmissible disease), suggested that the parents take the girl to New York City. The trip was made forthwith. Unfortunately, the attorney had not taken the time to learn that New York law does not permit sterilization of the non-resident retarded person. She was later sterilized by a Georgia physician after the necessary legal requirements had been completed.

In the case of two patients from one rural county, the retardation was documented, and surgical schedules set-up for sterilization. Then, the two young girls refused to come. Knowing that the law provided for such persons to appeal the decision of the local Judge of the Ordinary, the issue was dropped with the proviso that the local public health nurse get the girls into the family planning clinic for another type contraceptive method.

Another potential failure that ended up as a success relates to a 16 year old, Gravida II, Para I, who had been delivered in a small rural hospital. Her mother instituted steps to document retardation and obtained a court order for sterilization at MCG. However, before completion of the legal arrangements, the young girl again conceived. She was frightened of the big Talmadge Hospital and refused to come to Augusta in spite of her mother's efforts. The public health nurse visited the local M.D. and requested that he visit the girl in her home to offer

prenatal care and make the necessary changes in the legal papers to permit him to sterilize the girl on postpartum day three in the local hospital. Two babies later, the girl is now unable to again become pregnant, thanks to the resourcefulness of the public health nurse, the determination of her parent, and the cooperation of the local M.D. and Judge of the Ordinary.

With the exception of the cases mentioned, for the most part, very excellent cooperation has been forthcoming from all community agencies, the courts, the Judges of the Ordinary, the psychologists, the attorneys (including OEO's legal aid for the medically indigent), parents, staffs of Departments of Family and Children Services and others.

Several case histories will be presented in Part II of this paper. The first will be of interest, since it was from this case that we adapted the locally developed forms for consent and the other legal documents. The typical case could be pictured as a retarded single, never-pregnant sexually active girl unable or unwilling to use a contraceptive method effectively. A few cases have been processed who are the severely retarded pregnant multigravida, whose children of necessity have to be cared for by someone other than the incompetent mother. These have come to the attention of the residents during prenatal care. For these patients the sterilization procedure, very conveniently and economically, has been done on postpartum day three. It might be of interest that several of the referrals, now coming to MCG are for retarded males. One such case is the brother of a young girl who is currently a candidate for sterilization.

Type of Surgery

In the event the case (L.A.), was a postpartum sterilization, the operation (usually an Irvine or Pomeroy tubal ligation) was performed on postpartum day three. This is a simple procedure and adds only one day to the hospitalization stay. In several cases, the retardation was so profound as to make menstrual sanitation an impossible task for the patient. Such patients receive a total vaginal hysterectomy. Some saw this major surgery as potentially preventive of the development of uterine and cervical pathology in the later years of a patient's life, as this type patient is the type who visits an M.D. only when in severe pain or for advanced symptomatology.

Laparoscopic Sterilization

Since the initiation of the Laparoscopy Program, many sterilizations are being done through the laparoscope. Laboratory tests are done prior to the day on which the patient comes as a walk-in to surgery. Laparoscopic sterilizations here are usually done under general anesthesia. The patient enters surgery on day one; leaves the hospital on day two.

Cost of Procedure

In the early days of the new law and the performance of sterilization surgery, many patients who were on welfare came great distances to MCG because there were no fiscal provisions for the cost of medical and hospital charges, a cost that can be absorbed by a state institution such as MCG. When the funding problem was presented to the State Board of Health in 1971, they passed a regulation that those on medicaid could have the procedures paid for by medicaid funds. As a result many patients, until the Alabama incident, were having sterilizations in their own local accredited hospitals by local physicians. It was a gratifying experience to have this happen in a distant south Georgia county. Since we had assisted with the carrying out of the legal prerequisites for the original case referred to MCG, on the occasion of a second case, the Director of Family and Children Services quite competently took over and Medicaid paid the bill; best of all, the patient was able to be hospitalized in her own home town. The Washington DHEW directive has changed all this! We have reverted to a 1970 situation!

Though our medical records system does not permit exact count of cases, at the present time, the writer and one social worker have been involved with almost every case that has come through ETMH and University Hospital. The figure 25 represents a fairly accurate estimate of the number of sterilizations of the mentally retarded for the three years the law has been invoked in this area.

As referred to earlier, it has been our role to assist local agency officials and private physicians in the initial case, following which they have continued the program locally with very little or no help from us. All who have had a part in the program recognize the long, involved and tedious paperwork in this procedure, but the wisdom of the authors of the law in efforts to protect the rights of the retardate make it an endurable burden. Of all the sad sights in an OB-GYN Clinic, there is none more tragic than the confused, bewildered, pregnant retarded girl. Of all the preventable unwanted pregnancies, prevention of progeny to such individuals might well be one of the most humanitarian acts that can be performed for the good of the potential mother, the unborn child and ultimately, society.

It is hoped that the experience and review of MCG's cases of sterilization of the retarded will be of interest and benefit to all in Georgia who agree

with Dr. John Rock's great proclamation, "Every child has the right to be well born and well nurtured."

It is also earnestly hoped that DHEW will amend the guidelines to permit states with experience to continue sterilization of the mentally retarded with medicaid funds.

Acknowledgements

We wish to acknowledge the contribution of Mrs. Marilyn A. Williams, ACSW, for her able work in preparing the program forms and her assistance in completing the several steps required by law for sterilization. ■

THE FUTURE OF THE DEPARTMENT OF HUMAN RESOURCES: MAG'S POSITION

At the July 14, 1974 meeting of Executive Committee of Council, the following suggested platform position for gubernatorial candidates regarding the future of the Department of Human Resources was approved.

The Department of Human Resources and its Board should be reorganized to accomplish the following objectives:

A. The Department should consist of the present Divisions of Physical and Mental Health, Family and Children's Services and the State Office of Economic Opportunity. Offender Rehabilitation and Vocational Rehabilitation should be taken out of this department. Vocational Rehabilitation should be placed under the Department of Education.

B. The Board of Human Resources must be removed from domination by the Governor's office. This can only be accomplished by allowing the Board to select the Commissioner, set the terms of employment and be empowered to remove him from office.

C. Authority to prescribe policy must reside with the Board. Authority to remove from office employees who do not adhere to policy must be absolute (consistent with Merit Board regulations). Board Authority to appoint all top level administrative personnel should be recognized.

D. Physicians should constitute a one vote majority on the Board of Directors.

E. Professional associations such as medicine, dentistry, pharmacy, etc., should have greater input to the nominating process for subsequent appointment to the Board.

F. The divisions of physical health and mental health should both be under the direction of the Health Director who should be an M.D. The directors of these two divisions should also be M.D.'s.

G. Governor should appoint a reorganization commission with proper staff and finances to accomplish the details of reorganization. This should be done during first year of next administration.

WATS LINE MISUSE

In October 1973, MAG introduced a new service to members, a Wide Area Telephone System (WATS) line through which long distance incoming calls can be made toll free to MAG Headquarters.

Since this service was begun, the line has received heavy use, exceeding most months the 15-hour base time for which we contracted. We hope that the line has stimulated closer communication between the membership and Headquarters office and officers.

However, a survey of calls received on the WATS line shows that a good percentage, at times as high as 50 per cent of the calls, do not originate from member physicians or from their offices, but from patients, hospital administrators and the public in general. Many calls for the CHAMPUS program, in particular, come to MAG through its WATS line and must be re-routed.

We remind you that your dues pay for this service and ask that you refrain from making the number available to the general public.

As an aid, the following list of telephone number of MAG and related programs and organizations is provided so that more calls will be made correctly the first time:

Medical Association of Georgia	(404) 876-7535
	WATS Line 1-800-282-0224
CHAMPUS	(404) 875-9505, 9506
Georgia Medical Care Foundation	(404) 875-7254
	WATS Line 1-800-282-2614
Georgia Regional Medical Program	(404) 876-8231
Research and Development	(404) 875-5546
	WATS Line 1-800-282-1803

Pica remains a problem among pregnant, low-income women in both urban and rural areas of Georgia.

Pica in Pregnancy

EDWIN S. BRONSTEIN, M.D., M.P.H. *and* JERRY DOLLAR, M.D., *Augusta**

PICA IS THE LATIN WORD FOR MAGPIE, a bird noted for its fickle appetite and habit of eating almost anything. The term is generally used to denote the eating of a foreign substance. Pica is usually found in poverty areas among pregnant women whose diet is inadequate. One theory as to the cause of pica is that pica satisfies hunger sensations in women whose diet is poor. Another explanation is that the pregnant woman is instinctively seeking some mineral, especially calcium or iron, for which her body now has a great need. Pica is also considered a cultural practice of women seeking social approval by their peers.[1] Heilmeyer[2] suspects that iron deficiency may play a part in causing the symptoms of pica in pregnant patients. It has long been known that black women in the South consume varying quantities of clay, starch and chalk during pregnancy. The chalk is white clay or kaolin that has been sun-dried in blocks and can be found in numerous exposed deposits along the road beds in Georgia. Clay can also be purchased in small packages for 25 cents per pound in several small grocery stores in Augusta, Georgia. The starch usually consumed is a well-known dried laundry starch. Thus, all forms of pica in this area are readily available to the community.

Frequency and Effect

The purpose of this study was to determine the frequency and the effects of pica in pregnant, low income women from both urban and rural areas in Georgia. This is part of a continuing study of nutrition in pregnancy, the Nutrition Demonstration Project, which is investigating the effect of nutrition on the outcome of the pregnancy. Another purpose of this study of pica was to examine the changes which have occurred in the last five years since a similar study of pica was made by O'Rourke[3] in the same community.

* From the Department of Obstetrics and Gynecology of the Medical College of Georgia in Augusta, Ga. 30902. Supported in part by: Grant No. 10-15-04-3300-65, Goldberger Fellowship, AMA Council on Foods and Nutrition; Grant No. CC-D000011-0-01, Nutrition Demonstration Project, Community Demonstration Project in Nutrition; and Grant No. 04-8-000009-02-0, Maternity and Infant Care Project, Richmond County Department of Public Health, Department HEW, Maternal and Child Health.

Procedure for Study

The patients selected for study were 410 pregnant women, mostly low income blacks, who were part of the Nutrition Demonstration Project conducted at the Obstetrical clinics of the Eugene Talmadge Memorial Hospital and University Hospital in Augusta. On the initial prenatal visit, each patient was interviewed by a nutrition counselor who questioned her food frequency, social and dietary history and the practice of pica. During the initial visit, each patient was also seen by the laboratory team. Hemoglobin, hematocrit, hair root protein, serum albumin, vitamins A, C, E, urea/creatinine ratio, serum iron and iron binding capacity were determined on each patient. Patients were categorized by age, parity and place of residence. Alternate patients in each group were identified as program patients and had the special care of the nutrition counselors while the other patients had the usual care provided in our Maternity and Infant Care Project by a nutritionist. All patients with pica were selected from the first 410 patients. The next patient who entered the program after each pica patient was selected as a control. The control and pica groups were compared by age, place of residence, number of previous pregnancies, type of substance eaten, anemia, serum albumin, urine urea/creatinine ratio, serum iron and iron binding capacity. The obstetrical history, complications and outcome of the pregnancies were also examined.

All blood samples on urban patients were taken in the morning because of the diurnal variation of serum iron where the highest levels are noted in the morning. This procedure was also used because of the effect of oral iron on serum values for several hours after ingestion.[4] Blood samples on rural patients were also done in the morning but most were tested after the start of vitamins and iron because of scheduling problems. Serum iron and TIBC were done by the methods of Fisher and Price[5] and Giovanniello.[6] This paper will report on the serum albumin, urea/creatinine ratio, serum iron, TIBC and characteristics of patients practicing pica.

Results

Residence: Of 410 women interviewed, 209 were rural dwellers and 201 were urban dwellers. Sixty-five (16 per cent) women admitted the practice of pica; 37 rural patients (18 per cent) compared to 28 urban patients (14 per cent) (Table 1). There is no significant difference in the practice of pica between rural and urban patients ($p = .30$).

Types of Pica: Patients ingested a variety of substances, with laundry starch being the most common (Table 2); chalk was the second most frequently eaten and clay was ingested by only nine per cent of all patients with pica. Those who practiced pica in rural and urban areas exhibited no significant difference in the substances which they eat (p is greater than .30).

Age of Patients: Forty-three per cent of the urban group with pica were 16 to 19 years of age. Seventy-three per cent of the rural patients with pica were 20 to 35 years of age, as compared to 32 per cent in the rural control group (Table 3). Pica patients tend to be older than non-pica patients ($p = .06$ and older rural patients show a greater tendency to practice pica than young rural or urban patients (.05 is less than p which is less than .10).

Number of Previous Pregnancies: The mean number of past pregnancies among pica patients was 1.7, while the mean number among the control was 1.3. The number of pregnancies did not influence the practice of pica among urban or rural patients (Table 4).

Anemia: Twenty-nine per cent of pica patients had anemia, defined as hemoglobin of less than 10 gms./100 ml. or a hematocrit of less than 30 per cent. Anemia was more prevalent among patients with pica (29 per cent) than among controls (13 per cent) ($p = .03$). There was no significant difference in frequency of anemia among urban (36 per cent) and rural patients (25 per cent) with pica (p is greater than .30). Pica patients showed no significant difference in the frequency of anemia by age (p is greater than .20) (Tables 5 and 6). The mean hemoglobin for all pica patients was 10.8 and the mean for all control patients was 11.8.

Iron Deficiency: Carr[4] described a serum iron/TIBC ratio of less than 16 as significant anemia. In 49 patients who had serum iron and TIBC done, 15 (55.5 per cent) of the pica patients and only 3 (13.6 per cent) of the control patients had values below 16 (see Table 7). Eight patients of the 18 with iron/TIBC ratios less than 16 per cent had no anemia, using less than 10 gms./100 ml. of hemoglobin as the criteria of anemia. This suggests pica patients have iron depletion as well as iron deficiency anemia. If we use values of 10 gms./100 ml. as the level of anemia in our prenatal clinic, we are missing almost 50 per cent of pica patients with iron depletion. Fifty-three and eight tenths per cent of patients with pica had very low serum iron levels. (See Table 8.)

Serum Albumin: The low normal value of serum albumin was 3.50 gms./100 ml. Twenty-two (36.6 per cent) of the pica patients had levels below 3.5 gms./100 ml. In the control group, 23 per cent demonstrated low values and only 1.5 per cent had values less than 3.23 gms./100 ml. (Table 9). Pica patients show a greater tendency to have very low

TABLE 1
FREQUENCY OF PICA BY PLACE OF RESIDENCE

	Rural		Urban		Total	
	No.	%	No.	%	No.	%
Non-Pica	172	82	173	86	345	84
Pica	37	18	28	14	65	16
Total	209	100	201	100	410	100

TABLE 2
TYPE OF PICA BY PLACE OF RESIDENCE

Substance Eaten*	Rural		Urban		Total	
	No.	%	No.	%	No.	%
Chalk	16	42	8	27	24	35
Starch	14	37	17	57	31	46
Clay	3	8	3	10	6	9
Other	5	13	2	7	7	10

* Patient may have ingested more than one type of pica.

TABLE 3
FREQUENCY OF PICA BY AGE AND RESIDENCE

	Rural				Urban			
	Pica		No Pica*		Pica		No Pica*	
Age	No.	%	No.	%	No.	%	No.	%
12-15	3	8	2	5.4	2	7	0	0
16-19	7	19	19	51.4	12	43	14	50
20-35	27	73	12	32.4	14	50	14	50
>35	0	0	4	10.8	0	0	0	0
Total	37	100	37	100.0	28	100	28	100

* Control group.

TABLE 4
FREQUENCY OF PICA BY NUMBER OF PREVIOUS PREGNANCIES AND PLACE OF RESIDENCE

	Rural				Urban			
Number of Previous	Pica		No Pica*		Pica		No Pica*	
Pregnancies	No.	%	No.	%	No.	%	No.	%
0	14	38	20	54	14	50	13	46
1-2	12	32.4	10	27	8	29	10	36
3-5	9	24.3	6	16	4	14	4	14
>5	2	5.3	1	3	2	7	1	4
Total	37	100.0	37	100	28	100	28	100

* Control group.

serum albumin values than non-pica patients (p is less than .01).

Urine Urea/Creatinine Ratio: The low limit was 3.50. The mean value of patients with pica was 3.99. Twenty-six (40.6 per cent) patients demonstrated low values. The mean value of the controls was 4.35 and 13 (20 per cent) of the patients demonstrated low values (Table 10). Pica patients show a greater tendency to have low urea/creatinine ratios than non-pica patients (p = .015).

Discussion

A reduction in the frequency of pica is noted in this rural population. In 1966, O'Rourke[3] found the incidence of pica among rural patients to be 55 per cent as compared to 18 per cent in this study. Nutrition education efforts and routine iron supplementation are provided to all patients of the Maternity and Infant Care Project which serves Richmond and the surrounding 10 rural counties. In July 1970, an additional program of intensified nutrition education and counseling was provided through the Nutrition Demonstration Project by six nutrition counselors and a public health nutritionist. The rural counties of the Maternity and Infant Care Project have shown significant reductions in infant mortality, perinatal mortality, prematurity and maternal mortality during the years of the program. One can only assume that nutrition counseling efforts and the routine supplementation of iron have resulted in the reduction of pica frequency. O'Rourke[3] stated that there was no significant difference of anemia between pica patients and controls when anemia was defined as hemoglobin less than 12 gms./100 ml. Examination of O'Rourke's data reveals a significant difference of anemia in pica patients (33 per cent) as compared to controls (12.2 per cent) when anemia was defined as a hemoglobin of less than 10 gms./100 ml. There is a significant increase in the frequency of anemia among patients with pica according to our data.

TABLE 5

FREQUENCY OF ANEMIA* IN CONTROL PATIENTS BY AGE AND PLACE OF RESIDENCE

Age of Patient	Rural				Urban			
	Anemia		No Anemia		Anemia		No Anemia	
	No.	%	No.	%	No.	%	No.	%
12-15	0	0	2	5	0	0	0	0
16-19	4	11	15	41	3	11	11	39
25-30	2	5	10	27	0	0	14	50
>35	0	0	4	11	0	0	0	0
Total	6	16	31	84	3	11	25	89

* Less than 10 gms./100 ml. Hgb. or 30% hematocrit.

TABLE 6

FREQUENCY OF ANEMIA* IN PATIENTS WITH PICA BY AGE AND PLACE OF RESIDENCE

Age of Patient	Rural				Urban			
	Anemia		No Anemia		Anemia		No Anemia	
	No.	%	No.	%	No.	%	No.	%
12-15	1	3	2	5	0	0	2	7
16-19	1	3	6	16	3	11	9	32
20-35	7	19	20	54	7	25	7	25
>35	0	0	0	0	0	0	0	0
Total	9	25	28	75	10	36	18	64

* Less than 10 gms./100 ml. Hgb. or 30% hematocrit.

TABLE 7

SERUM IRON/TIBC RATIO IN PICA AND CONTROL PATIENTS BY NUMBER AND PERCENT

	Pica		Control		
	No.	%	No.	%	Total
Fe/TIBC <16%	15	55.5	3	13.6	18
Fe/TIBC >16%	12	44.4	19	86.4	31
Total	27	100.0	22	100.0	49

The serum iron/TIBC ratio is a measure of the degree of iron deficiency and was low in 55.5 per cent of the patients with pica and 13.6 per cent of the controls. Finch[7] states that iron deficiency can be defined at several levels; iron depletion, iron deficient erythropoiesis and iron deficiency anemia. Pica is associated with an increased frequency of both iron depletion and iron deficiency anemia.

Pica patients tend to be older than non-pica patients. If adequate nutrition education, quality prenatal care and diets supplemented with iron can be provided to the younger age group, hopefully, a smaller percentage will develop the practice of pica.

Several reasons for pica were given by patients, the most common being that the women "just had a taste for it." Others said that their parents told them to do it, or they really liked the taste of it. Some said that they did not know why they did it. Edwards,[8] in a similar population, found the relationship between pica and diet. The diets of clay and corn starch eaters were found to be lower in calories, calcium, iron, thiamine, and niacin than were the diets of their control group. In a follow-up study Edwards[9] found mild anemia to be present among clay eaters; this finding supports our data. A possible mechanism of this anemia was advanced by Minnich[10] who found that clay was very effective in blocking iron absorption. Clay may act as a cation exchange resin; calcium and magnesium in clay are replaced by iron, placing the iron in an unabsorbable form. Pritchard[11] noted that the ingestion of sizeable amounts of starch or clay just prior to the iron did not appreciably impair iron absorption. The starch, if it did contribute to the iron deficiency, did so by

providing calories without iron rather than impairing iron absorption.

Serum albumin was demonstrated to be significantly low (p is less than .01) in 36.6 per cent of the patients with pica and 23 per cent of the controls. The low values for the serum albumin, as well as the urine urea/creatinine ratio may be reflections of low protein intake and poor nutrition of pica patients. Pica is usually found in poverty patients where the dietary intake is poor and a state of undernutrition may exist. Forty and six tenths per cent of the patients with pica had low urine urea/creatinine ratios ($p = .015$).

The biochemical and hematologic results of pica and control patients demonstrate that some of the nutritional problems found in poverty are pica, protein undernutrition, iron deficiency and anemia. When pica exists, the frequency of these deficiencies increases. Whether the iron deficiency and the poor nutrition come before pica or whether pica is followed by iron deficiency and anemia has not been demonstrated here. Probably both are true; this is in agreement with Moore.[12]

Conclusions

The initial data of the Nutrition Demonstration Project indicates that the frequency of pica among urban and rural patients in the Maternity and Infant Care Project has diminished. Although pica has decreased in frequency, it still persists and may be the cause of iron deficiency and anemia in many of our pregnant patients. The practice of pica should be identified early in pregnancy. The patient should be provided iron and counseled to improve her dietary habits. Nutrition education and counseling as well as other nutrition services are an integral part of the Maternity and Infant Care Project. Diets high in protein with adequate calories are stressed and all patients are given an iron supplement in pregnancy to improve iron deficiency and prevent anemia.

Acknowledgement

We gratefully acknowledge the assistance of Dr. Richard E. Pogue, Ms. Betty Villere, Ms. Joyce Daniel, Ms. Sally Owens and Ms. Toni Cooke in this project. ■

TABLE 8

SERUM IRON IN PICA AND CONTROL PREGNANT PATIENTS BY TOTAL, MEAN NUMBER AND PERCENT OF PATIENTS WITH LOW VALUES

	Pica	Control
Total Number	26	23
Mean	60.1	98.5
Number Low	18	11
Percent Low*	69.2	47.8
Number Very Low	14	2
Percent Very Low†	53.8	8.7

* Less than 85 mcgms./100 ml. is low limit.
† Less than 60 mcgms./100 ml. is very low limit.

TABLE 9

SERUM ALBUMIN AMONG PREGNANT PATIENTS WITH PICA AND A CONTROL GROUP BY NUMBER, MEAN VALUE AND PERCENT OF PATIENTS WITH LOW VALUES

	Pica	Control
Total Number	60	65
Mean	4.24	3.74
Number Low	22	15
Percent Low*	36.6	23
Number Very Low	9	1
Percent Very Low†	15.0	1.5

* 3.50 gms. % is low limit.
† 3.25 gms. % is very low limit.

TABLE 10

URINE UREA/CREATININE RATIO AMONG PREGNANT PATIENTS WITH PICA AND A CONTROL GROUP BY NUMBER, MEAN VALUE AND PERCENT OR PATIENTS WITH LOW VALUES

	Pica	Control
Total Number	64	65
Mean	3.99	4.35
Number Low	26	13
Percent Low*	40.6	20.0

* 3.50 is low limit.

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Surgery may be helpful in the prevention of diplopia and enophthalmos.

Current Concepts in the Management of Blowout Fractures of the Floor of the Orbit

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In 1957 Byron Smith and John Converse[1] initially recognized and described the clinical entity of "blowout fracture of the orbital floor." At that time acute surgical intervention in patients with radiographic evidence of a fracture or clinical findings of abnormal ocular motility was recommended. It was felt that with early surgery, in almost all cases, permanent double vision or the cosmetic blemish of enophthalmos would be avoided. With 15 years of clinical experience the reassessment of surgical indications and expectations, and the recognition of surgical complications, have made us realize that the problem is not a simple one, the surgery is not benign, and the results, despite early surgery, are disappointing in a large percentage of cases. This clinical experience, shared by all, has made everyone recognize the necessity for conservative management in a large number of cases.

Criteria for Surgical Intervention

The rationale for surgical intervention has been to prevent specific complications, diplopia and enophthalmos. Surgery should not be performed on patients with blowout fractures just "because it's there" radiographically.

Diplopia

In patients with blowout fractures that have ocular motility problems, there is some question of "how much good" we are doing these patients by early surgical intervention. In one comparative study, Emery and Von Noorden[2] reviewed 67 patients with blowout fractures and double vision. Forty-nine underwent early surgery and 18 were unoperated. The unoperated group had less permanent double vision than the operated group; and, what is more, within 15 days in the unoperated group, one half of the group had complete resolution of the double vision as the edema subsided and the hemorrhage absorbed.

Several clinical series (see Table 1)[3, 4, 5] have shown that even with early acute surgical intervention there is a high percentage (22 per cent-25 per cent) of residual double vision requiring subsequent extraocular muscle surgery for correction. There is a high probability that surgical manipulation of an edematous and hemorrhagic extraocular muscle, whether entrapped or not, leads to irreparable damage and fibrosis of the muscle. After 18 years of clinical experience, Byron Smith[6] now feels that many early muscle problems including restriction of the eye to passive rotations, or a positive "traction test," may be due in part to edema and hemorrhage within the muscle and orbit. He feels that if there is a great deal of edema present, it is better to delay surgery until most of it has subsided; and, if the muscle situation is improving with repeated prism and cover measurements, one is justified in delaying surgery for an extended period.

Enophthalmos

The causes of enophthalmos following blowout fracture are shown in Table 2 and it is important to understand that only the first two causes are treatable. Enophthalmos rarely, if ever, occurs in

TABLE 1
DIPLOPIA AFTER BLOWOUT REPAIR

	Cases		Severe
Cole, Smith—1963	27	22%	22%
O'Bear—1967	43	46%	23%
McCord—1970	11	41%	28%
Emery, Von Norden—1971	49	49%	25%

* Assistant clinical professor of ophthalmology for Emory University and chief of staff for Metropolitan Eye and Ear Hospital in Atlanta. Dr. McCord's practice is at 326-B Doctors Building, 490 Peachtree St., N.E., Atlanta, Ga. 30308.

TABLE 2

CAUSES OF ENOPHTHALMOS FOLLOWING BLOWOUT FRACTURE

1. Increased orbital volume
2. Loss of orbital contents
3. Fibrous retraction of soft tissue of orbit

the acute situation because of tissue swelling and hemorrhage which may cause a slight exophthalmos. It is well known that patients with sizeable fractures on x-ray may never become enophthalmic. Smith recommends delay of surgery if there is significant edema for an extended period of time since enophthalmos may not occur. If it does, corrective surgery may be performed at any time in the future and is much more precise after the subsidence of edema. Emery and Von Noorden[2] found the same incidence of late enophthalmos in the group that underwent early surgery and those that were unoperated. Other series[4] also show a comparable incidence of late enophthalmos despite early surgery because of inaccuracy of correction.

It is important to recognize that soft tissue and muscle shrinkage and fibrosis can cause a retraction of the globe and enophthalmos without orbital volume change or adhesions to bone. This is almost impossible to correct surgically and is seen in patients who have had massive hemorrhage in the orbit and in many cases have undergone the trauma of early surgical exploration. When anticipating surgical correction of enophthalmos, one must perform a forward "traction test" to rule out its presence or one will invariably be disappointed in the surgical result.

It is, of course, clear that many cases of blowout fractures do require surgical correction; however, the timing of the surgery should be determined by the amount of edema and hemorrhage present. It is felt that early surgical intervention is indicated in those cases with little or no edema that have evidence of restricted eye movements or acute enophthalmos. In cases that have motility disturbance with significant edema, the surgery should be delayed 10 days until the edema subsides. If the eye movements are followed with prism and cover measurements and shown to be steadily improving, the surgery should be further delayed. In the presence of significant edema, it is felt that acute surgery for enophthalmos should not be performed.

Surgical Techniques

The approach for repair of blowout fractures of the orbit has included the transcutaneous eyelid approach, the Caldwell-Luc with antral packing, and a combined approach. With regards to the exploration for and treatment of entrapped extraocular muscles, the only satisfactory approach is the direct exposure of the orbital floor through the eyelid which allows visualization of the tethered extraocular muscle. With placement of the skin incision just underneath the lashes, the cosmetic blemish is imperceptible. The Caldwell-Luc with antral packing has been used alone in cases with large comminuted fractures without motility problems. There is a high rate of failure in curing motility problems when the Caldwell-Luc is used alone.[4, 7, 10] There also have been reported cases of postoperative entrapment of previously free extraocular muscles causing double vision where there was none before with the use of antral packing alone.[7] The most disastrous operative complications reported have been cases of acute blindness from closure of the central retinal artery and optic atrophy.[8, 9] Most cases occurred with antral packing in which the pressure of packing was transmitted to the orbit; however, it has occurred also with large orbital implants. Multiple other less catastrophic operative complications have also been reported.[10]

Ophthalmic Consultation

In view of the high incidence of ocular complications in blowout fractures (see Table 3)[10, 11, 12] and the now recognized ocular complications associated with surgery, patients with blowout fractures should have thorough ophthalmic evaluation whether or not surgery is anticipated. Some of the more common intrinsic globe injuries found are hyphema, traumatic iris rupture, rupture of the globe, choroidal rupture, commotio retinae and intraocular hemorrhage, acutely; and, later optic atrophy and retinal detachment may occur. Since the need for acute surgery must be determined by repetitive and accurate measurements of ocular motility, and since postoperatively a significent percentage of patients need further ocular surgery or treatment, it would seem prudent and in the best interest of the patient that ophthalmic consultation and management be considered essential. ■

TABLE 3

SERIOUS OCULAR COMPLICATIONS WITH MIDFACIAL FRACTURES

	Pt.	%
Miller—1967	34	26
Fradkin—1971	23	40
Emery, Von Norden	159	24

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HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

July 14, 1974

AMA Computer Assistance Program: Voted to postpone MAG participation until next year and present the matter to the House of Delegates in 1975.

Department of Human Resources: Acceped the objectives or reorganization as presented and voted that a copy of these objectives be directed to the candidates for governor and lieutenant governor requesting comment. They should be sent also to presidents of the county medical societies and published in the *Journal of the Medical Association of Georgia.*

Appointments: *Committee on Access to Health Care* —Nicholas E. Davies, Atlanta; Thomas N. Lumsden, Clarkesville and Ollie O. McGahee, Jesup. *Ad Hoc Committee to Evaluate Peer Review Mechanisms*—Edwin C. Evans, Earl W. Hathcock, Thomas J. Florence, William S. Davis, Joseph S. Wilson, Richard S. Colvin, W. Dan Jordan, John R. McCain and Mark Silverman of Atlanta; Robert H. Vaughan, Columbus; Wells Riles, Jonesboro; Milton B. Satcher, East Point; John H. Reed, Jr., Gainesville; Ollie O. McGahee, Jesup; LaMar S. McGinnis and Forest D. Jones, Decatur; Joseph M. Turner, Tifton; John I. Dickinson, Rome; Donald J. McKenzie, Thomasville; D. R. Mahan, Dalton; and Julian K. Quattlebaum, Jr., Savannah. *Medical Disciplinary Investigating Committee*—1st District, Samuel P. Tillman, Statesboro, Fred J. Coleman, Dublin and John Ell Hendley, Millen; 2nd District, Albert S. Trulock, Jr., Albany, Donald J. McKenzie, Thomasville and J. Daniel Bateman, Albany; 3rd District—Bob R. Maughon, James H. Sullivan and Bruce C. Newson, Columbus; 8th District—W. O. Inman, Jr., Brunswick, Joe C. Stubbs, Valdosta and Neal F. Yeomans, Waycross; 9th District—Charles R. Andrews, Canton, E. W. Holloway, Commerce and Hartwell Joiner, Gainesville. *Committee on Peer Review*—Katherine Stuckey, Decatur (anesthesiology); and James H. Alexander, Atlanta (pediatrics). *Medical Nominating Commission* to the Board of Human Resources—Ferrol A. Sams, Jr., Fayetteville; and J. Gary Palmer, Marietta. *Atlanta Area Family Planning Council*—Byron H. Dunn, Atlanta.

Tel-Med Program: Commended DeKalb County Medical Society for installation of the Tel-Med Program which has received excellent response.

PSRO Repeal Program: Discussed the recent action of the AMA House of Delegates on PSRO and voted to send a copy to MAG delegates and to inquire if May 1974 action should be modified, for a report to Council in September.

Research and Development: Heard a request to develop a project concerned with the collection of health care data in which MAG would be involved with Medicare Part B claims, with approval given for preparation of a proposal for circulation to Executive Committee as proposal deadline for submission is August 6.

Georgia Medical Care Foundation: Heard certain recommendations regarding the proposal made by Blue Cross of Atlanta and Columbus about the CHEC program and voted to disapprove this proposal.

An illustrative case of this rare condition is reported along with a brief survey of the literature.

Volvulus of the Stomach

H. TURNER EDMONDSON, M.D. *and* P. R. VEAZEY, M.D., *Augusta**

VOLVULUS OF THE STOMACH is a rare but serious condition. The first published report was by Berti[4] in 1866. His patient died from high intestinal obstruction, and the diagnosis was made at autopsy. A recent review of the world literature by Cole[9] indicates that approximately 250 cases have been reported. Two-thirds of the reported cases were chronic and often had only relatively minor obstructive symptoms. However, in those cases which were acute, i.e., when the stomach was strangulated or obstructed, a true abdominal emergency existed.[7, 10, 13, 14, 15]

Classification

The following classification of volvulus of the stomach by Singleton is often quoted.[17, 18]

Organoaxial: Rotation of the stomach around its long axis (Figure 1). This type is usually associated with diaphragmatic hernia and displacement of the stomach into the chest. In other words, a displaced stomach may twist about its longitudinal axis and produce incomplete or complete volvulus.

Mesenterioaxial: Rotation of the stomach from right to left (or left to right) about the long axis of the gastrohepatic ligament (Figure 2). This type necessitates an unusual laxity or absence of the duodenal or gastric mesenteric attachments.

We report an additional case of mesenterioaxial volvulus of the stomach in which the pylorus rotated from right to left, and its anterior surface came to rest against the splenic hilum.

Case History

A 72-year-old caucasian male, who was a long term psychiatric inpatient, was transferred to the VA Hospital Surgical Service because of acute onset of vomiting and large epigastric mass. The mass was



FIGURE 1

Organoaxial volvulus: the stomach twists about its longitudinal axis.

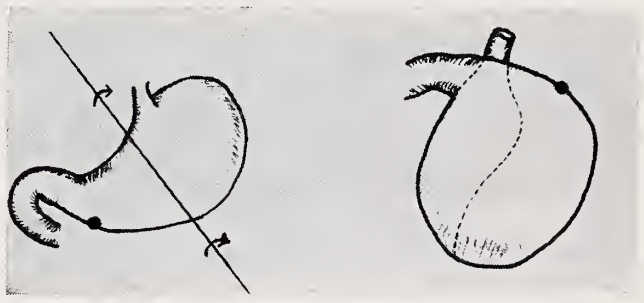


FIGURE 2

Mesenterioaxial volvulus of the stomach: after a right to left rotation, the antrum and duodenal bulb are located in the most superior portion of the abdomen.

partially reduced after insertion of nasogastric tube and release of gastric fluid.

Past history revealed that he had implantation of pacemaker three months previously for cardiac arrythmias. Otherwise, the history was non-contributory.

Routine admission laboratory studies were essentially normal. Plain x-rays of the abdomen were reported as showing only gastric dilatation. Upper gastrointestinal barium studies were reported as follows (Figure 3), "Barium was instilled into the stomach through nasogastric tube. There is an anomalous malrotation of the stomach. The body of the

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stomach turns toward the left with the antrum and duodenal bulb located in the most superior portion of the abdomen. The only position in which barium would empty from the antrum of the stomach was with the patient in the prone-oblique position and in Trendelenburg." The radiologist's diagnosis was, "Mesenterioaxial malrotation with the stomach forming a complete circle with the antrum and duodenum lying superiorly."

The patient appeared in no real distress, but his schizophrenic status probably influenced his response. The temperature was 37.7°C, pulse 109, and respirations 28. Examination of the abdomen revealed a large, non-tender, tympanitic epigastric mass, which generally conformed to the shape and size of the stomach. Peristaltic sounds were normal.

A tentative diagnosis of volvulus of the stomach was made, and he was operated upon without delay. When the abdominal cavity was opened, a mesenterioaxial gastric volvulus was discovered. The duodenum and pyloric mesenteric attachments were considerably elongated. These viscera were supported by a pedicle and therefore, in an intraperitoneal position. The right to left rotation had allowed the anterior pylorus to come in contact with the splenic hilum (Figure 3). There was no evidence of strangulation and all structures appeared viable. Inasmuch as the stomach was markedly elongated, a 60 per cent partial gastrectomy with a retrocolic Billroth II gastrojejunostomy was performed. By shortening the stomach and bypassing the pedunculated duodenum, this operative procedure appeared to effectively correct any tendency towards recurrent volvulus.

The postoperative course was uneventful. Three months later, a repeat upper gastrointestinal x-ray was within expected limits for postgastrectomy status, and the patient has had no further symptoms.

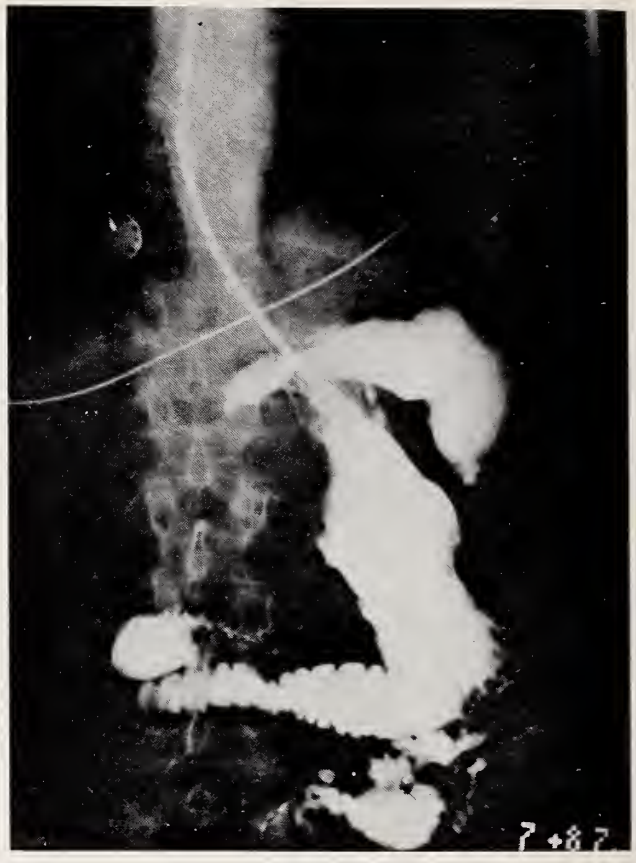


FIGURE 3

Upper gastrointestinal barium study which shows a mesenterioaxial volvulus of the stomach. The body of the stomach is turned towards the left with the antrum and duodenal bulb located superiorly.

Etiology

The etiology of a gastric volvulus lies in the anatomy of the region. It is obvious that the ligamentous attachments of the stomach must be relaxed or absent before the volvulus can occur. Predisposing anatomical anomalies can be congenital or acquired.

Congenital defects have been described as one or more of the following: diaphragmatic defects; abnormalities in the embryonal rotation of the intestine with concomitant abnormal fixation; failure of normal fusion of the mesenteries of the fetal viscera; or congenital bands or adhesions.[9]

Significant acquired conditions which have been implicated are diaphragmatic hernias, high-lying left hemidiaphragm after pneumonectomy, stomach tumors, distention of the colon, and increased intestinal peristalsis.[2, 8, 9]

Age and Sex

Gastric volvulus can occur at any age. Cole, in 1971, reported two cases in infants. One was a five-month old female and the other a newborn female. He reviewed the literature and found that only 44 cases had been reported in which the patient was less than 12 years old.[3, 16, 20, 21]

There does not appear to be a sex predisposition.

Symptoms and Signs

In 1904 Borchardt[6] recorded the following triad of symptoms and signs: (1) localized distention of the stomach and a relatively flat contour of the lower abdomen; (2) difficulty or impossibility of passage of a nasogastric tube; and (3) vomiting or unproductive retching. Our patient essentially demonstrated this triad except that passage of a nasogastric tube presented no real difficulty.

The x-ray picture usually shows a distended viscus in the upper left or midabdomen. Two fluid levels are often seen.[11] Contrast x-ray examination, as in our patient, may be striking and show a complete inversion of the gastric curvatures with reversal of direction of contrast media flow.

The symptoms of chronic or recurrent gastric volvulus may be difficult to distinguish from those of gallbladder disease, peptic ulceration, or gastritis. Barium x-ray examinations between attacks of discomfort may show a normal picture or possibly some underlying or associated condition such as hiatal hernia. Thus, the picture may be confusing and only by careful evaluation of the symptoms along with suspicion can the diagnosis be made reasonably early.

Treatment

Immediate decompression with a nasogastric tube is recommended if possible. In our case this resulted in temporary relief of gastric distention and fullness. Surgical intervention is mandatory without delay when the volvulus is acute. It is often impossible to reduce the volvulus without emptying the stomach, which may require trochar aspiration. After the acute torsion has been corrected, attention must be directed to the underlying cause. Rarely, the patient's condition may not permit an extended operative procedure at the time; therefore, a temporary gastrostomy may be indicated which can be followed by a later second operation.

In order to permanently prevent recurrence, one or more of the following may be employed:[5, 7, 9, 12, 19]

1. Repair of diaphragmatic hernia. The most common type of mild volvulus is that associated with paraesophageal hiatus hernia. Simple repair of the defect may give lasting results.

2. Gastropexy. Simple fixation to the anterior abdominal wall. This is usually not a lasting cure, as the sutures will often slacken and the volvulus will recur.

3. Gastropexy with colonic displacement. This operation was designed when volvulus is associated with eventration of left diaphragm. In this procedure the transverse colon and greater omentum are separated from the stomach, and thus having been mobilized are shifted to fill the left subphrenic space. The stomach is then sutured to the anterior abdominal wall.

4. Fundo-antral gastrogastrostomy. In this procedure the two portions of the rotated stomach are connected by anastomosis. However, the original predisposing anatomic defect has not been dealt with which explains why the procedure has not gained popularity.

5. Partial gastrectomy. This may be unnecessarily severe in mild cases of torsion and must be reserved for cases when the antral and duodenal ligaments cannot be otherwise shortened, and particularly when there is associated peptic ulcer disease.

Prognosis

Delayed surgical intervention is very hazardous in acute volvulus. Once strangulation has occurred, the mortality is reported from 25 per cent to 50 per cent.[1] However, in the absence of advanced strangulation and necrosis, prompt relief of the torsion with subsequent correction of the predisposing defect should result in a favorable outcome. Most of the recorded fatalities have been the result of procrastination and delayed operative intervention. A reasonable suspicion of the possibility of gastric volvulus, along with careful appreciation of the usual symptoms and radiographic picture, should prompt one towards early surgical treatment and usually a favorable prognosis. ■

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Highlights of AMA House of Delegates Actions

This summary of the 123rd Annual Convention of the AMA, held June 23-27, 1974 in Chicago, Illinois, covers many of the subjects considered at the meeting but is not meant to be a complete report of all actions taken.

A CHANGE IN THE METHOD of electing AMA trustees, a definitive policy statement on PSROs, the need for additional safeguards to preserve the confidentiality of medical records and new recommendations which affect the relationship between hospitals and hospital medical staffs were among the important items approved by delegates at the 123rd Annual Convention.

Meeting for a total of 19 hours and 38 minutes, the House acted on 66 reports and 137 resolutions for a total of 203 items of business.

The House approved bylaws changes which replace the "slot method" of electing trustees by the "simultaneous election of candidates to several positions of equal rank," in which all candidates run for board vacancies on a single ballot. Under the new method, trustees for full, three-year terms are elected first, followed by the selection of trustees to fill unexpired terms. Election of the AMA president-elect, vice-president, and speaker and vice-speaker of the House remains on a separate basis.

Delegates selected Max Parrott of Portland, Oregon as president-elect.

Elections

In addition to Dr. Parrott, others elected or re-elected to positions in the Association were:

Vice-President, Joseph M. Ribar, Alaska; Speaker of the House, Tom E. Nesbitt, Tennessee (re-elected); Vice-Speaker of the House, William Y. Rial, Pennsylvania (re-elected).

Trustees, for three-year terms: Daniel Cloud, Arizona; James M. Blake, New York; Hoyt D. Gardner, Kentucky; Ramond T. Holden, District of Columbia (re-elected). For the unexpired two-year term of James H. Sammons, AMA executive vice president-designate, Frank J. Jirka, Illinois, and for the unexpired one-year term of Dr. Parrott, Joe T. Nelson, Texas.

Inaugural Address

In his inaugural address, Dr. Malcolm C. Todd, the new AMA president, urged the AMA to sponsor the development of a "national policy on health" to place needs and goals in focus.

Dr. Todd asked the delegates to consider sponsoring a National Academy of Health to formulate his proposed national policy. The academy, he said, would give both private and public sectors of health care "an open forum and framework in which to exchange views, pinpoint health care needs, evaluate total health care resources, and arrive at some common sense of purpose, with sound programs, goals and priorities."

He also urged the association to: (1) organize the development guidelines to protect the privacy of patient information accumulated in computerized health care centers. No inherent right of the patient "is greater—or presently more imperiled—than what he tells his doctor." (2) To assume a "new and strong coordinating role" in medical education, partly so that it will give more attention to human concern for patients. "If the AMA is to be held accountable for what our profession does, then it must insist upon more responsibility for the manner in which our profession is trained." (3) To establish a "university without walls," to confer an advanced academic degree, stimulating more physicians to enroll in continuing education.

Remarks of Outgoing President

There is a new and welcome political awakening and a new activism within the ranks of medicine, according to Russell B. Roth, outgoing president of the AMA, in his final report to the House.

This rise in political activism—generated by various federal and other third-party health care proposals—comes none too soon, Dr. Roth said, citing the rising health-care activism among politicians.

Health care "offers unique attractions" to politicians who, with minimal risk, can crusade for the avowed "right" of every American to health care, he added. Because while politicians are blamed for blunders in most national and foreign affairs, "it's the doctors, the hospitals and the insurance companies who catch all the heat for problems in the health care field," Dr. Roth pointed out.

Yet both the public and the politicans are unable to differentiate between good medicine and "the fakes, the phonies and the frauds on the fringe of medicine," he said.

Dr. Roth cited as "a curious exercise in fundamental ignorance" some federal legislators who favor rigid quality controls over physicians and osteopaths but agree to pay for chiropractic services in the same piece of legislation. It is against this background, he said, that Congress now wrestles with various NHI proposals, a fact that could make 1974 a banner year for the politically ambitious.

Summary of Actions

PSROs: Speculation over possible changes in PSRO policy by the House dominated the attention of those attending the convention, including the media. The House adopted the following resolution on PSRO:

> *Resolved, That this House of Delegates instruct the Board of Trustees of the Association to direct its efforts to achieve constructive amendments to the PSRO law and to ensure appropriate regulations and directives, with particular effort directed*

at amending those sections of the law which present potential dangers in the areas of confidentiality, malpractice, development of norms, quality of care, and the authority of the Secretary of HEW; and be it further

Resolved, That the Association should continue its efforts to achieve legislation which allows the profession to perform peer review in accordance with the profession's philosophy and the best interest of the patient; and be it further

Resolved, That individual state associations which elect non-participation shall not be precluded from such a position by this Association's policy statement, but should be urged to develop effective non-PSRO review programs which embody the principles endorsed by the profession as constructive alternatives to PSRO; and be it further

Resolved, That if ongoing evaluation of the PSRO program reveals that it does, in fact, adversely affect the quality of patient care, or conflict with Association policy, the Board of Trustees be instructed to use all legal and legislative means to rectify these shortcomings.

Extension of Policy on National Health Insurance: Two statements on national health insurance were adopted after lengthy debate. One calls on the Board of Trustees to cooperate with state associations "to attempt to devise mechanisms mutually acceptable to the private medical and insurance communities which will ensure the provision of health insurance coverage through the purchase of private health insurance, and to seek means to secure favorable Congressional and public support for their adoption."

During discussion, it was pointed out that the addition to the NHI policy does not affect AMA support for Medicredit but is intended to stimulate new health insurance mechanisms. The second resolution calls on the AMA and component associations to work to detach "any national health insurance program from the controlling intrusions of existing PSRO laws and regulations."

Oppose "Public Utility" Medicine: The House went on record as being opposed to certain bills in Congress which would replace the federal "Health Professions Educational Assistance Act: which expired June 30. Under the bills, comprehensive health planning programs would be replaced with public utility type bodies which would control certain aspects of health education and health care delivery, and medical licensure. An amended resolution adopted by the House directs the Board of Trustees to mobilize AMA membership in opposition to offensive sections of the proposed legislation, and take strong actions on other fronts.

Standard Insurance Claim Form: Requests the AMA to work with third parties to secure increased acceptance of the AMA uniform health insurance claim form, and urges state associations to encourage acceptance of the form by insurance commissioners, and, if necessary, through state legislation.

Confidentiality of Patient Records: The House adopted two reports bearing on confidentiality of medical records. One describes a wide-ranging series of proposals to enable the medical profession and insurance companies to "maintain the confidentiality and security of patient information." A second notes that the Council on Legislation is developing model legislation as a guide to possible state legislation to preserve confidentiality, and that a model bill should be ready for consideration by the House at the 1974 Clinical Session in Portland, Oregon.

In other actions affecting physicians and the public, the House directed that:

- The new national blood policy be privately implemented through the appropriate organization of the AMA, state and county medical societies and their committees on transfusion.
- The AMA continue to inform the public and the profession of the potential problems and risks in permitting the non-physician substitution of drugs of choice prescribed by physicians, and that state associations support this position before state legislatures considering laws which would allow drug substitutions.

Report on Physician-Hospital Relations, 1974: The House adopted the 104-page "Report on Physician-Hospital relations, 1974," compiled by the Council on Medical Service and its Committee on Private Practice. An update of an earlier report made in 1964, the 1974 version contains 14 specific recommendations to cope with problems developing between some hospitals and their medical staffs. Among other things, the recommendations are aimed at protecting medical staffs against unilateral action by hospital governing boards relative to staff bylaws, rules and regulations.

New Liaison Committee on Medical Education: Delegates adopted a Board of Trustees Report calling for the establishment of a new Liaison Committee on Continuing Medical Education. Structure and duties of the new committee have been worked out by AMA representatives and those representing the American Board of Medical Specialties, the American Hospital Association, the Association of Medical Specialties, and the Council of Medical Specialty Societies.

In other actions, the House:

- Supported a moratorium on the licensure of allied health occupations until the end of 1975.
- Adopted a report containing "Essentials of an Accredited Educational Program for the Surgeon's Assistant."
- And reaffirmed the AMA's opposition to blanket pre-admission certification of hospital patients by governmental or hospital edict.
- Adopted a resolution urging the AMA to support the development of preceptor programs in primary patient care to stimulate the production of more primary care physicians.

Malpractice Problems: A resolution calling on the AMA and constituent societies to "institute a nationwide public education program to inform the public" of malpractice problems, and for the AMA to "spearhead state and federal legislation" to correct malpractice inequities, was referred to the Board of Trustees and its Committee on Insurance for report back at the 1974 Clinical Session.

In miscellaneous actions, the House changed the name of the Section on Plastic and Reconstructive Surgery to the "Section on Plastic, Reconstructive, and Maxillofacial Surgery," and adopted a substitute resolution calling upon the AMA to recognize "brain death" as one of the various criteria by which death may be medically diagnosed. ■

editorials
editorials
editorials

The Year of the Nevus

A mole on the neck,
You shall have money by the peck.
Old English rhyme
(from "Familiar Medical Quotations")

THE CHINESE CALL IT THE YEAR OF THE RAT. The American Heart Association has designated it the Year of Hypertension. Travel agents and the State Department call it the Year of Europe. To me, it is the Year of the Nevus. During the first six months of 1974 I have heard enough hairy mole stories (pun intended) to last a decade. Let me tell you a few.

Early this year a patient of longstanding came to my office and said that he had to have a mole removed, fast. He had had the lesion for as long as I have known him. It was blue-black, located between his navel and his symphysis pubis, and I had urged him to have it taken off on numerous occasions. So when he presented himself as an emergency to see about having it excised, I couldn't help wondering what had caused his urgency. He described it this way. "Me and the old lady was having relations last night and this thing started to bleed a little. When we got through, she seen the blood on her belly and she said to me, 'I'm cuttin' you off 'till you get that thing cut off,' so here I am." We got the "thing" cut off—it was a melanoma. We hope his anti-neoplasm immune system (or whatever it is that God gave us to protect us against "things") is in order.

Economic Aspects

Ben Okel's mole story was a good one. As a matter of fact, it was so good it was reprinted in the AMA News. Dr. Okel is the President of the Dekalb County Medical Society. His editorial, first published in their Bulletin, dealt with the economic aspects of mole removal. He recounted the story of a friend who was charged $200 for the removal of two tiny cutaneous malignancies—sutures were not involved and the procedure took about 15 minutes. Thereafter, he checked the fees of the surgeons to whom he referred his patients, and he states, ". . . I recently referred a patient to a general surgeon who removed 218 basal-cell carcinomata at a charge of only $250.00. Simple arithmetic reveals that I saved this patient (or his carrier) more than $20,000 in 'Surgeon's fees.'. . ."

After reading his editorial, I thought that this must be the best (or worst) mole story of the year. And it was, for about a week, until a friend of mine accosted me with another. It seems that he had a small mole on his face, so he consulted a plastic surgeon and had it removed. The procedure took 15—maybe 20—minutes. A few days later the sutures were removed. The pathologist reported the nevus was benign, the scar was neat, all was well. All was well, that is, until he received the bill. Two hundred fifty dollars, plus $12 for removing the sutures! Thinking that there must be some mistake, he called the doctor's office. There had been no mistake.

Somehow these mole stories didn't turn out so well. I had thought, naively, that perhaps Dr. Okel's editorial would do some good, at least in DeKalb

County. But if the surgeon read it, it made no impression. I am left to conclude that for some reason, or combination of reasons—greed and avarice, apotheosis of the Almighty Dollar, a gross insensitivity to human anxiety, or simply a giant egotism—this physician had the gall to charge $250 for a simple 20 minute procedure.

Profit from Misfortune

Some may argue that my friend should have inquired about the fee and then found another surgeon. After all, medicine is under the free-enterprise system; each physician may charge what he feels his services are worth. In my opinion this argument is unfounded. In the first place, medicine is clearly not free enterprise although we do operate within this system. It would be simple, for example, for a group of physicians in the same specialty to fix prices. Second, it would be disastrous if our patients felt that they had to shop around each time they saw a new doctor. But the ultimate reason is this: people come to a physician because they are ill, or because they fear they may be ill, or because they are anxious to keep from becoming ill. In my opinion, there is no way to justify charging huge fees and becoming wealthy on our fellow man's misfortunes of illness, fear and anxiety.

So, the question, as I see it, comes down to this—how do you define huge fees? This I do not know, but it must certainly involve wide ranges that are related to knowledge, industry, skill, experience and many other factors. When this subject is brought up in medical gatherings, physicians will compare their fees and their incomes with those of lawyers and real estate brokers and corporate executives. Yet their purpose in life is to make money, to amass wealth; ours is to heal. Those people have no mandate to be compassionate, to relieve suffering, to "abstain from whatever is deleterious and mischievous."

You think this is Utopian? Perhaps it is, to a degree. But we could get along without lawyers and without real estate agents and without most executives. We shall never get along without healers.

Push Toward Government Control

Because we physicians have failed to police our ranks, the public is slowly turning for help to the only group over whom they have control, the politicians. Each time a fee-gouging physician enrages a voter, especially a vocal one, it pushes medicine a little closer to the government control that we dread so much. Our medical leaders would have us do battle with the federal government. I, for one, would prefer to clean up our house, on our own, without outside help. Once this is done, then we can take on the government and anyone else who challenges us with those muddle-headed schemes for health salvation of the masses.

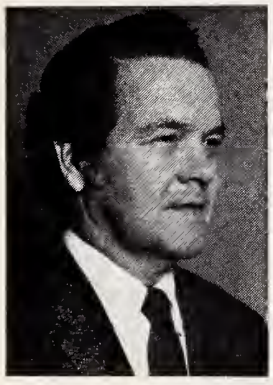
The way I see it, we are all in this mess together—practicing physicians, academicians, medical students (especially the medical students) and others. Whatever happens to our health care system will affect us all. We will do well to remember the famous words of John Donne.

> "No man is an Island, intire of itself; every man is a peace of the Continent, a part of the maine; if a Clod bee washed away by the Sea, Europe is the lesse, as well as if a Promontorie were, as well as if a Mannor of thy friends or of thine owne were; any mans death diminishes me, because I am involved in Mankinde; And therefore never send to know for whom the bell tolls; It tolls for thee."

Nicholas E. Davies, M.D.
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president's letter

An Introspective View of a Vacation . . .

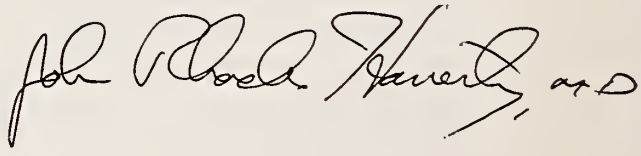


I started out in Chicago, politicking with physicians from all over the U. S.
I began my vacation when that was over.

I had an elegant dinner in Milwaukee with a German restauranteur: an old friend.
I saw a Spanish shipping magnate, aboard his African freighter, inching through the locks of Sault Ste. Marie.
I lodged with a Scot Innkeeper beside a fish-filled lake on Manitoulin Island.
I bought souvenirs from a wonderful old Indian woman in Ontario.

I crossed two inland seas by steamer.
I saw fine performances of Shakespeare's "Pericles" and Shaw's "The Devil's Disciple."
I explored the Canadian woods and streams on foot.
I heard the Toronto Symphony perform outdoors under a full summer moon.

I rediscovered a few old values I had forgotten.
I gained a few new perspectives I should have known before.
I got outside of my usual self for a little while.
I rested, and refreshed myself, and refilled my cup.
That's what vacations are supposed to be all about . . . aren't they?



John Rhodes Haverty, M.D.
President, Medical Association of Georgia

heart page
heart page
heart page

Guidelines in the Drug Treatment of Angina Pectoris

JOHN E. FRAZIER, II, M.D., *Atlanta**

THIS ARTICLE IS INTENDED to serve as a guideline for the drug treatment of angina pectoris secondary to coronary atherosclerotic heart disease (CAHD). Medication dosages are only approximate; drug regimens must be individualized. The rules for medical management are simple, however, and their application is based upon logic derived from knowledge of the determinants of myocardial oxygen consumption (MVo_2). Angina pectoris occurs when myocardial oxygen demand exceeds supply. When due to CAHD, critical narrowing of one or more coronary arteries is implied. The capacity for severely diseased vessels to expand and thereby increase oxygen supply is limited by the very nature of the obstructing lesions themselves. Therefore, the goal of therapy is to reduce myocardial oxygen requirements.

In simple terms, the rules for accomplishing this goal are as follows: 1) slow the heart rate; 2) reduce blood pressure; 3) maintain the smallest possible cardiac size; 4) reduce the "vigor" of myocardial contraction. These rules for the treatment of angina pectoris are formulated from the major determinants of MVo_2 which are: 1) heart rate, 2) myocardial-wall tension and 3) contractile state of the myocardium. Myocardial-wall tension is directly related to intraventricular pressure and ventricular radius ($T \cong \frac{Pr}{h}$). Contractility is determined by various positive and negative inotropic agents. Increases in any of these determinants, i.e., heart rate, pressure, radius, or contractility, increases myocardial oxygen consumption.

Drugs in Treatment

The major drugs used in the treatment of angina pectoris are nitrites (nitroglycerin), long-acting nitrates (isosorbide dinitrate) and beta-adrenergic blocking agents (propranolol hydrochloride). The additional requirement for tranquilizers during periods of stress and the need for antihypertensive medication seem obvious when one considers that angina pectoris may occur at a remarkably predictable point as expressed in terms of the systolic pressure times rate product. This double product (SBP × HR) at point of angina reflects stress on the myocardium and is an indirect index of that level of myocardial oxygen consumption which exceeds the oxygen delivery capacity of the coronary circulation.

It is important to emphasize that each medication may exert and influence on several determinants of myocardial oxygen consumption. It is the net effect of each that must be considered. Nitroglycerin probably exerts its major influence by reducing both mean systemic arterial blood pressure and ventricular radius. Total coronary blood flow is little affected. Venodilatation due to nitroglycerin results in reduced venous return and diminished ventricular volume. At the same time, nitroglycerin may be associated with reflex tachycardia which increases myocardial oxygen consumption. Its net effect, as is well known to all, is reduction in

* 35 Collier Road, N.W., Atlanta, Ga. 30309. Prepared at the request of the Committee on Physician Education of the Georgia Heart Association.

MVo_2 and relief of angina. When angina pectoris occurs infrequently, e.g. once per week, sublingual nitroglycerin may be all that is needed. Isosorbide dinitrate, either sublingual or chewed, may be added to nitroglycerin when pain occurs frequently, e.g., daily. The usual regimen is 5 mgs. sublingually q 6 hours. This may be increased to 5 mgs. q 2-3 hours if pain is encountered at rest or with slight exertion. When prescribed in high dosage, hospitalization is often required; blood pressure should be closely monitored. Its mechanism of action is similar to that of nitroglycerin. Nitrol paste applied to the forearm may achieve the same therapeutic effect while the patient is sleeping.

When dealing with a changing pattern of angina or when a reduction in sympathetic tone becomes desirable, propranolol may be added to the basic regimen of nitroglycerin and isosorbide dinitrate. Clinical improvement with beta-adrenergic blockade is brought about by a reduction in heart rate, myocardial-wall tension and contractility. In the presence of congestive heart failure, advanced AV block, bradycardia and bronchial asthma, propranolol is contraindicated. The initial dosage is usually 10-20 mgs. q 6 hours. In an hospitalized patient, this dosage may be increased by 40 mgs. per day every other day until an approximate dosage of 160-320 mgs. daily is reached or the desired therapeutic effect is achieved. Outpatient therapy suggests the need for smaller incremental increases of this medication, perhaps weekly. Sinus bradycardia with heart rate less than 50-55 per minute should be avoided. Caution must be used since congestive heart failure may be precipitated in some patients with only small daily dosages, e.g. 40-80 mgs. daily.

When cardiomegaly or congestive heart failure is present, myocardial-wall tension is increased. In this situation, digitalis, despite its positive inotropic effect and diuretics may together bring about a net beneficial effect by reducing heart size. Digitalis and diuretics may also be especially useful when nocturnal angina is present. A nighttime increase in ventricular dimensions due to resorption of dependent edema into the intravascular compartment is thought to increase ventricular radius and myocardial oxygen consumption. Reduction in cardiac size by improving ventricular function with digitalis and diuretics reduces MVo_2 by reducing myocardial-wall tension. In many instances, digitalis and diuretics may be administered in conjunction with propranolol. The undesired actions of each medication may be partially avoided in this manner. When angina pectoris persists despite maximum medical management, coronary artery by-pass surgery may be quite helpful provided favorable anatomy (proximal lesions), good distal run-off and preserved ventricular function can be demonstrated at coronary arteriography.

Choice Depends on Determinants

In summary, choice of any therapeutic regimen depends upon which determinants of myocardial oxygen consumption one wishes to alter. The heart rate may be slowed by tranquilizers or propranolol; blood pressure reduced by antihypertensive agents, propranolol, and in some respects, nitroglycerin or isosorbide dinitrate; myocardial-wall tension reduced by propranolol, nitrites, diuretics and in some instances digitalis; and contractility reduced by propranolol. It has been my custom to use nitroglycerin initially followed by isosorbide dinitrate, propranolol and/or digitalis in that order. As experience accumulates with use of propranolol in angina pectoris this medication may be used quite early. It must be realized that angina pectoris does not necessarily follow an inexorable course and that for reasons not yet fully explained, predictable patterns of angina may become unstable for sometime and then become predictable again. Use of the above agents, alone or in combination, may assist the practitioner in achieving his desired end result, i.e., relief of angina pectoris. The mechanisms described, though by no means complete, should provide a basis upon which to choose a rational therapeutic regimen. ■

The Physician a Hospital Employee?

J. WINSTON HUFF, *Atlanta**

THE LIABILITY OF A HOSPITAL for the negligence of its staff physicians has been a topic of continuing interest and continuing development.

While a hospital is not generally liable for the negligence of the physicians who practice there, special factual situations can result in liability on the part of the hospital. The Darling case[1] has been widely discussed since it was decided in 1965 by an Illinois court. There the Court based the hospital's liability on a finding that the hospital had been independently negligent in failing to require consultation with a specialist by the general practitioner involved. The hospital was held to have permitted the physician to violate the hospital's own rules requiring consultation.

New Grounds for Responsibility

The Georgia Court of Appeals has recently issued an opinion[2] indicating another ground on which the hospital may be responsible for the professional conduct of its staff doctors. The question reviewed in this case was whether the doctor was an "independent contractor," or was the "servant" (employee) of the Newton County Hospital. If he was an independent contractor the hospital would not be liable for the doctor's negligence unless the hospital was itself independently negligent in some other respect, such as in the Darling case. On the other hand, said the Court, if the doctor was found to be an employee of the hospital, then the hospital would be responsible for his professional activities in the same manner as for nurses, orderlies and other employees.

In this case, the hospital filed an affidavit signed by its Administrator stating the following facts: The physician involved had been hired to manage the emergency room during the evening and night hours and on weekends; the physician was duly licensed, and was serving his military obligation as an officer in the United States Public Health Service; the emergency room physician was in sole control of the emergency room facilities and the hospital did not have the right to exercise any control over the method or manner of diagnosis or treatment of emergency room patients; the physician was paid $12 per hour by the hospital and his work schedule was controlled by the Administrator.

After reviewing the affidavit the Court proceeded to discuss the legal principles involved. The Court cited earlier cases for the proposition that a physician who practices in a hospital is not ordinarily considered an employee. Thus, unless the hospital was negligent in the selection of the physician or undertook to control the manner of treating the patient, the hospital would not be liable for the doctor's misconduct, even though it takes place in the hospital. The Court contrasted the situation in which a doctor admits his patient to the hospital with that where a person is taken to a hospital and is treated by a physician hired by the hospital. If, in the latter case, the physician is guilty of malpractice in diagnosing or treating

* Prepared at the request of The Medical Association of Georgia. Mr. Huff is a partner in the firm of Powell, Goldstein, Frazer & Murphy, general counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, Atlanta, Ga. 30303.

the patient, the hospital may be liable simply because the physician is an employee. The Court said that where a doctor is paid a salary by the hospital, spends all his working hours under the direction of the hospital staff and does not maintain a practice of his own, he will normally be regarded as an agent or employee of the hospital.

True Test of Employee

Following a well established principle of law, the Court said that the true test whether a person is an employee or an independent contractor is whether the employer has the right to direct the time, the manner, the method and the means of execution of the work. The Court determined that the Newton County Hospital Administrator's affidavit indicated that the hospital did have the right to control the *time* its emergency room physicians would work. The Court then concluded that it could not decide that the hospital was not liable on the basis of the affidavit alone and that the case would have to be tried by a jury.

This decision seems to be a departure from prior decisions. As late as 1969 the Georgia Court of Appeals decided[3] that an emergency room physician employed by DeKalb General Hospital was not an "employee." In the DeKalb case there was a written contract which designated the physician as an "independent contractor." The Court there held that a hospital is not liable for the negligence of an employed physician where the negligence relates to a matter of professional judgment on his part and the hospital does not exercise, and has no right to exercise, control of the diagnosis and treatment of patients. This test was the only substantive test applied in the DeKalb case. There was no discussion concerning the hospital's control over the time the emergency room doctors had to be on duty.

The affidavit of the Hospital Administrator in the Newton County case specifically stated that the hospital had no right to exercise control over the professional activities of the emergency room physicians. Thus, if we applied the DeKalb reasoning to the Newton case, the hospital should have won. However, in the Newton County case, the hospital was held liable, while in the DeKalb County case the hospital was not held liable. It would seem somewhat artificial to lean solely on the language of the DeKalb contract to the effect that the physicians were "independent contractors."

Other Areas for Problems

The matter of malpractice liability is not the only problem where an employer-employee relationship is found to exist. Should the hospital deduct Social Security, unemployment compensation and withholding taxes? The Internal Revenue Service in a revenue ruling[4] last year, declared that where a pathologist contracted to conduct and operate a hospital laboratory as its director, he was an employee of the hospital and the hospital would have to collect Social Security and unemployment tax, and to withhold on his wages.

We have not seen the last of the developments in this area. Physicians who contract with hospitals should carefully review their contracts in the light of this new court decision. ■

REFERENCES

1. Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d, 326 211 N.E. 2d 253 (1965).
2. Newton County Hospital v. Nickolson decided June 18, 1974.
3. Pogue v. Hospital Authority of DeKalb County, 120 Ga. App. 230, 170 S.E.2d 53.
4. Rev. Rul. 73-417.

I've told this before . . . .

(Ed. note: Careful observation of a puzzling ritual by backyard robins helped solve one mystery of Nature for author J. G. McDaniel, M.D. of Atlanta. Other contributions are solicited and may be mailed to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Bird Nests

I HAVE OFTEN WONDERED how and when birds choose a place to build their nests. Several springs ago I noted some activity by a pair of robins that may give a little clue.

Our home has three stories in the back and we sleep on a sleeping porch that faces the east. On that side we are well up in the pine trees that flourish there—many near the house.

When daylight comes I wake up when the birds first begin to chirp. On this particular morning I noticed a mother robin doing some peculiar gyrations out near the end of a branch that had several forks. It was a sort of a dance, she jumped up and down on smaller limbs, then on the main part, turned around and around and actually shimmied. I watched all this with some wonderment. Some time later after dressing, I walked back on the sleeping porch to see if my friend was still dancing—No!! She wasn't, but there was a white piece of string about 6-8 inches long draped over the limb.

For some 10 days, the first thing I looked at near sunrise was that string, then one morning I saw both mother and father dancing on the limbs, fluffing their feathers and turning around and around. The next morning a nest was halfway built, the following morning completed. About a week later mother robin was setting on the nest.

The dance is understandable—they were testing the strength of the limbs as they built the nest. I saw them belly down and go around and around making it conform to their bodies—but the white string and the interval of 10-14 days puzzles me. I could not find other white strings.

Could it be that birds test several likely spots and mark them some way weeks in advance, then finally choose one?

J. G. McDaniel, M.D.
820 W. Wesley Road, N.W.
Atlanta, Georgia 30327

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NEW MEMBERS

Aziz, Ezzat M. Richmond—Active—PD	MCG Augusta, Ga. 30902
Gertner, Harold R. MAA—Active—SU	1968 Peachtree Road, N. W. Atlanta, Ga. 30309
Hleap, David MAA—Active—FP	4555 N. Shallowford Road Atlanta, Ga. 30342
John, Fares Richmond—Active—PATH	MCG Augusta, Ga. 30904
Johnson, Clarence E., Jr. Bibb—Active—SU	870 High St. Macon, Ga. 31201
Keeton, William F. DeKalb—Active—ANES	DeKalb General Hospital Decatur, Ga. 30033
Keith, Thomas L. Hall—Active—ANES	Anes. Assoc. of Gainesville Gainesville, Ga. 30501
Lee, Eung M. DeKalb—Active—I	5372 Peachtree Road Chamblee, Ga. 30341
Nixon, Daniel W. Richmond—Active—ON	MCG Augusta, Ga. 30904
Seese, Perry G. DeKalb—Active—P	Emory University Clinic Decatur, Ga. 30030
Smith, John M., Jr. Glynn—Active—I	P.O. Box 1059 St. Simons Island, Ga. 31522
Tindall, Suzie C. DeKalb—Active—N	755 Columbia Drive Decatur, Ga.

SOCIETIES

The July 16 meeting of the **Bibb County Medical Society** featured a program on the Medical Explorer Scout Pack sponsored by the society. A group picnic was scheduled for August 8.

Leo Conroy, special agent-in-charge of the Atlanta Division of the Federal Bureau of Investigation spoke on the functions and responsibilities of the FBI before the July 15 meeting of the **DeKalb County Medical Society.**

PERSONALS

First District

Murray C. Arkin of Savannah has been certified as a Diplomate of the American Board of Allergy and Immunology. Dr. Arkin has practiced internal medicine and allergy in Savannah since 1958 and is a former chief of staff of Memorial Medical Center.

Third District

A. J. Kravtin, Columbus pediatrician, has been installed as president of District Grand Lodge Five B'nai B'rith at its annual convention in June. Dr. Kravtin is past president of Columbus Lodge, No. 77, state chairman of the B'nai B'rith Adult Jewish Education Committee and a past president of the Georgia State Association.

Columbus orthopedist **Joseph Carlos Serrato, Jr.,** was featured in the cover article of the April "La Luz," a Denver, Colorado based magazine for Spanish-Americans. Dr. Serrato is president and co-founder of the Foreign Medical Graduates Association, a recently-appointed member of the Finance Committee of the Democratic National Committee, and one of a few U.S. citizens initiated into the Mexican Academy of Culture.

Fourth District

R. Beauvais Randall of Decatur has been granted Fellowship in the American College of Cardiology.

Fifth District

Fred Allman, Atlanta, served as a panel member discussing podiatric sports medicine before the 62nd Annual Meeting of the American Podiatry Association August 8-13 in Atlanta.

Atlanta's **Joseph H. Dimon, II,** recently served as professor of the day at Rhode Island Hospital and guest lecturer at Massachusetts General Hospital.

James Funk, Atlanta, has been elected president of the Rocky Mountain Traumatology Society.

Sixth District

Tom Williams. Macon, is the newly elected president of the Georgia Chapter of the American College of Gastroenterology.

Seventh District

New officers for the medical staff of Redmond Park Hospital in Rome are **Raymond Waters,** president, **James Jenkins,** president-elect, and **Peter Gilbert,** secretary.

Eighth District

Albert Saunders of Valdosta, retiring from a near 50-year practice to devote his time to business, church and service interests, was the subject of a feature story in the June 28 *Valdosta Daily Times.*

Ninth District

Rafe Banks, Jr., Gainesville, has been named president-elect of the southeastern section of the American

Urological Association and will assume the presidency in April 1975. The Gainesville native was graduated from Emory University and Harvard Medical School. He is a fellow in the American College of Surgeons and a diplomat of the American Board of Urology.

Tenth District

John Robert Rinker, Augusta, was honored with a banquet in early June by the newly organized John Robert Rinker Urologic Society. Dr. Rinker was responsible for starting a urology residency program at the Medical College of Georgia.

Washington family physician **M. C. Adair** has been selected as director of medical education at Floyd County Hospital in Rome and his principle responsibility will be to develop a family practice residency program there.

Carl Jelenko, Augusta, is the author of "Tietze's Syndrome at the Xiphisternal Joint" in the July *Southern Medical Journal.*

DEATHS

Warren Candler Baxley

Blakely physician Warren Candler Baxley, Sr., 62, died June 7 following a heart attack. Dr. Baxley was born in Hephziabah, Ga. in 1912, and was graduated from the Medical College of Georgia in 1937. He began his practice in Blakely in 1939 after serving his internship and residency in Macon and Milledgeville hospitals. For five years during World War II he served in the U.S. Army.

Active in the community, Dr. Baxley was a charter member and first president of the Blakely Lions Club, a 33rd degree Mason and Shriner and member of the American Legion and Veterans of Foreign Wars. He was a member of the First United Methodist Church and served on its board of stewards.

Survivors include his widow, Mrs. Virginia Ann Holder Baxley of Blakely; daughter, Mrs. E. Parker Yutzler, Jr. of East Islip, N.Y.; two sons, Lt. Cmdr. Warren Baxley, Jr. of Pensacola, Fla. and Thomas H. Baxley of Athens; sister and three grandchildren.

Herbert M. Edge

Herbert M. Edge, 81, Blairsville family physician, died May 31 following a long illness. The Florida native had lived in Union County many years and was a member of the Dooley Masonic Lodge.

Survivors include his widow, Mrs. Chlo Edge of Blairsville; two sisters, Mrs. Ethel Standridge and Mrs. Bell Dixon of Cairo, Ga.; three grandchildren and two nephews.

Jasper Herman Lamm

Retired Atlanta physician Jasper Herman Lamm died in Macon June 23 at the age of 77. Dr. Lamm was born in Richmond, Va. and moved to Macon two and a half years ago after retiring from a 35-year service as an Atlanta physician. He was a graduate of the Medical College of Virginia and was a member of the Greenfield Masonic Lodge in Atlanta, Atlanta Optimist Club, Druid Hills Country Club and St. Luke's Episcopal Church.

Dr. Lamm is survived by his widow, Mrs. Alva Ricks Lamm of Macon; daughter, Mrs. R. C. Sauder of Macon; two sisters, Mrs. Jack Speight of Fountain, N.C. and Miss Eleanor Lamm of Lucama, N.C.; three grandchildren.

Charles Lewis Shorter

Atlanta physician Charles Lewis Shorter, 40, died June 9. Dr. Shorter was an Atlanta native and a graduate of Morehouse College and Howard University Medical School. He was a member of the Episcopal church.

Survivors include his widow; two daughters, Jay and Suane; brother, Dr. Henry F. Shorter, Jr.; father, Henry F. Shorter, Jr., all of Atlanta.

John Kelly Stalvey, Jr.

Sixty-five year old John Kelly Stalvey, Jr., Savannah, died June 14 in Candler General Hospital after a brief illness.

Born in Decksport, S.C., Dr. Stalvey had lived in Savannah 34 years and was in the practice of general surgery. He was a fellow of the American College of Surgeons.

Survivors include his widow, Mrs. Madelyn Spear Stalvey of Savannah; daughter, Mrs. Roderick Guerry of Savannah; son, John Thomas Stalvey of Savannah; mother, Mrs. John K. Stalvey of Conway, S.C.; sister, Mrs. James S. Rogers of Conway; two grandchildren; nieces and nephews.

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The Month in Washington

The humdrum hearings on national health insurance (NHI) before the House Ways and Means Committee got something of a lift when the long-absent chairman, Wilbur D. Mills (D-Ark.), unexpectedly showed up one Friday in mid-June and announced that whatever bill his committee approves undoubtedly would not look like any single bill presently under consideration.

This pronouncement from the august chairman immediately gave rise to the belief that closed door talks may be going on among conimittee members in an effort to hack out a compromise bill that could secure congressional enactment this year.

But the startling lack of interest evident in the House Ways and Means Committee hearings—only two or three members attending each hearing and chairman Mills showing up for just the second time in months—and the indefinite postponement of Senate Finance Committee hearings would seem to say the Congress is not busting its britches to pass a NHI bill this year.

Mills said his own plan (Mills-Kennedy) "doesn't do everything I would like it to do." He said, however, he believes the method of reimbursing physicians under Mills-Kennedy is better than under Medicare. It would eliminate the apparent discrimination between the city physician and the rural physician, Mills believes.

He declared his primary concern is that the poor receive at least as good medical services as the rest of the people. Referring to the compromise with Kennedy, he said, "We were trying to lay before the public a program we thought had a chance to pass." He said he wanted to avoid a bill that "would provide nothing more than catastrophic," which would cover only five per cent of the need. The compromise is subject to further compromise, Mills said. Castastrophic is the roof, and "we need the floor and walls along with the roof."

Mills said his intent with the Mills-Kennedy compromise NHI bill was not to exceed the cost of the Administration's "CHIP" plan and to come up with a different method of financing. He said the bill was introduced to present an alternative to the Administration plan for discussion and comment.

Sample Testimony

Here are selected sample bits of testimony from the many medical-health care oriented organizations who have trooped to Washington to have their say about NHI:

• The American Public Health Association urged more consumer policy input than provided in any of the major NHI bills before the committee and more preventive services benefits. APHA President C. Arden Miller, M.D. said the major measures for the most part provide insufficient benefits and controls.

• The American Association of Medical Clinics supported maintenance of the free enterprise system of health care, and said funding should be from mandated employer plans and general tax funds for the poor and medically indigent.

• The Colorado Health and Environment Council witness discussed the Colorado Community-Cooperative-Decentralized plan which emphasizes preventive medicine and home health care. The importance of the physician's office as a basic health care facility was stressed.

• The National Association of Social Workers favored the Kennedy-Griffiths, Health Security Act provisions.

• The American Academy of Family Physicians told the House Ways and Means Committee any NHI bill must provide that family physicians receive the same fee as other specialists when providing the same service. Family physicians should not be treated as "second class members of the health care delivery team," said James Price, M.D., Academy President.

Wealthier people should pay a greater portion of the cost for catastrophic coverage as provided in the American Medical Association's Medicredit plan, he told the committee.

"We are skeptical as to just how all-encompassing a program can be effectively administered by the federal government and would strongly urge that, insofar as possible, continued reliance be placed on the expertise which has been developed by the private insurance industry," he said.

Dr. Price opposed a provision of the Mills-Kennedy bill (Medicare for all) regarding payment for services by specialists, saying that the determination of which physicians should not be providing specific services should be left to their peers rather than the Social Security Administration.

• Another witness, Donald Schiff, M.D., of the American Academy of Pediatrics, said "we must build upon the strengths of our present medical care system, taking special pains to retain the currently productive programs such as Crippled Children's, Maternal and Child Health, and Children and Youth."

Preventive health services should encompass the entire pediatric age scale to 21 years, said Dr. Schiff. Deductibles and co-insurance should not be used for preventive health care for children or pregnant women, he asserted. Comprehensive child health care should be a spelled-out benefit, and increased funding of psychological services is necessary, according to the physician. He urged creation of a cabinet post Secretary of Health.

Blue Shield Comments

• Ned Parish, President of the National Association of Blue Shield Plans, said the concept of a totally tax-

supported and government administered national health program is "a solution for a problem which no longer exists."

"We have built in America a private system which extends to the vast majority of the population and serves most of them quite well," he said.

Declaring that the public does not support radical restructuring of the health system or its financing, Parish said federal action is clearly necessary that would strengthen private coverage and at the same time eliminate problems that "can never be resolved without the active participation of government."

He called for:

1. Federal financing of coverage for the poor and medically indigent.
2. Catastrophic coverage, not federally-financed, tied to a program of basic benefits.
3. Regulation of carriers with respect to covered benefits and solvency.
4. Minimum standards for coverage.
5. Free choice and maximum participation by the private sector.

• In other testimony, the U. S. Chamber of Commerce urged approval of its own mandated-coverage NHI plan as "realistic, reasonable and affordable." The Mills-Kennedy plan would lead to "federal domination of the health program" and impose excessive new payroll taxes, the Chamber said. The Administration's "CHIP" plan would significantly increase costs to small and medium sized businesses and the AMA's Medicredit plan is not comprehensive enough, according to the Chamber.

• Pharmaceutical Manufactures Association President C. Joseph Stetler said the Mills-Kennedy bill provision for a restrictive national formulary for outpatient drugs would distort prescribing decisions. The PMA is most concerned with the proposed price controls on drugs, Stetler testified. This would force a diversion of sales from research-based firms to the nonresearching sector, he said.

• The National Protestant-Catholic Hospital Association said the Mills-Kennedy bill does not adequately ensure that hospitals will be reimbursed for their costs and could force nonprofit hospitals "into a hand-to-mouth existence." Voluntary donations would cease, the Association warned.

• Consumer Federation of America—favored the labor-backed Health Security bill, and argued that sole reliance on payroll tax as in Mills-Kennedy is regressive. The Federation indicated it would prefer a program financed solely out of general revenues.

• National Cancer Foundation—all bills fall short of providing adequate catastrophic coverage.

• The National Association for Mental Health—legislation should emphasize outpatient services and stimulate Comprehensive Community Mental Health Centers.

• National Kidney Foundation—"We have major trepidation about the ability of existing administrative machinery to manage a NHI program of far greater dimensions and scope than the end stage renal disease program."

And so the testimony goes—mind boggling from the standpoint of volume to the two or three members of the Ways and Means Committee that must listen patiently all day long every Friday until mid-July.

University Appointment

P. O'B. Montgomery, M.D., of Dallas, has been nominated by the President to the Board of Regents of the new Uniformed Services University of the Health Sciences.

Dr. Montgomery, a professor of pathology at the University of Texas Southwestern Medical School, was named to serve the remainder of the four-year term of Anthony R. Curreri, M.D., recently appointed president of the new school. The nomination goes to the Senate for approval.

Other members of the board of the new school include Malcolm Todd, M.D., president of the AMA; Charles E. Odegaard, M.D., president of the University of Washington; Joseph D. Matarazzo, M.D., chairman of medical psychology, University of Oregon Medical School; Durward G. Hall, M.D., a recently retired Congressman from Missouri; Alfred A. Marquez, M.D., of San Francisco, and Lt. Gen. Leonard D. Heaton, MC, USA (Ret.).

Medical Deductions

Working on a sweeping tax reform bill, the House Ways and Means Committee tentatively has decided to change the tax laws affecting medical deductions and business expenses that would affect consumers and physicians.

Apparently with an eye on the possibility of a national health insurance program being enacted, the Committee voted to remove the present deduction for one-half the amount an individual pays for his health insurance premium (up to $150), and to increase the present three per cent of income floor applicable to medical expenses to five per cent. The one per cent of income test for drug costs would be abandoned, with the drug expenses coming under the five per cent medical expenses category. Only prescription drugs would be covered.

In addition, the Committee decided to do away generally with the sick pay exclusion under which a tax break is provided employees who are paid while sick beyond a certain length of time.

In the business field, the Committee closed the door on business expenses resulting from attending conventions overseas unless there is an overriding reason for holding the meeting abroad. Not counted would be Puerto Rico, Hawaii, and American possessions. All cruise ship business expenses would not be acceptable, if the Committee's decision should be enacted by Congress.

HMOs—Limited Utility

Florida's experience is that the average start-up time for a full service Health Maintenance Organization (HMO) is three to five years, Tampa physician-legislator Richard S. Hodes, M.D., has told the House Ways and Means Committee.

Testifying at the Committee's national health insurance hearings, Dr. Hodes headed a delegation of the National Legislative Conference, an organization of state legislators.

Dr. Hodes outlined Florida's recent activities in health services, noting that unless federal support is continued for such programs as Hill-Burton, Comprehensive Health Planning and Regional Medical Pro-

grams, a state's health program might be further snarled by adding national health insurance.

Dr. Hodes is chairman of the Florida House of Representatives Committee on Health and Rehabilitative Services, and heads the Human Resources Task Force of the National Legislative Conference's Intergovernmental Relations Committee.

Florida has had an HMO licensing act for over two years, he noted, but thus far, only five are licensed.

Careful licensing to ensure both the quality care and financial soundness has protected the patient, "but the experience has taught us a hard lesson," he said.

"This lesson is that the average start-up time for a full service HMO is from three to five years, and that the popular conception of HMOs as a panacea for our ills is unfounded," said Dr. Hodes.

"In fact, HMOs have a somewhat limited utility since the institution is totally dependent on resources within the community," he said.

Rural HMOs will require more time and planning before they can become one of the remedies for rural health needs, he added.

HIGHLIGHTS OF COUNCIL

June 8-9, 1974

AMA Computer Assistance Program: Heard a discussion of the AMA Computer Assistance Program now available to state, county and specialty society organizations for use in the computerization of their membership records, and authorized the Executive Committee to make a final decision on the question of whether or not MAG should use this system.

Georgia Medical Care Foundation Scope of Activities: Heard a report on the specific scope of Foundation activities and requested a mailing to the members with further discussion in September.

PSRO Repeal. Received report on progress of repeal PSRO effort—communications with other states, update of tent cards, pamphlets, cassette presentation of educational programs for physicians and continuation of Washington contacts. Having heard a report of exact expenditures to date in repeal program, appropriated funds for further repeal work. Also heard announcement that proposed contract for PSRO planning had been withdrawn.

Foreign Medical Graduates: Heard report from committee that attorney had been requested to investigate possible legislative solution to the problem.

GMCF: Instructed the Foundation to proceed to implement CHEC.

EMCRO: Directed the MAG President to write the Chief of Staff of each of the state's hospitals asking that EMCRO be allowed to present its data system to the medical staff.

GaMPAC: Received information that a series of meetings would be held, one in each congressional district, for the purpose of allowing GaMPAC members to discuss the candidates to receive GaMPAC support.

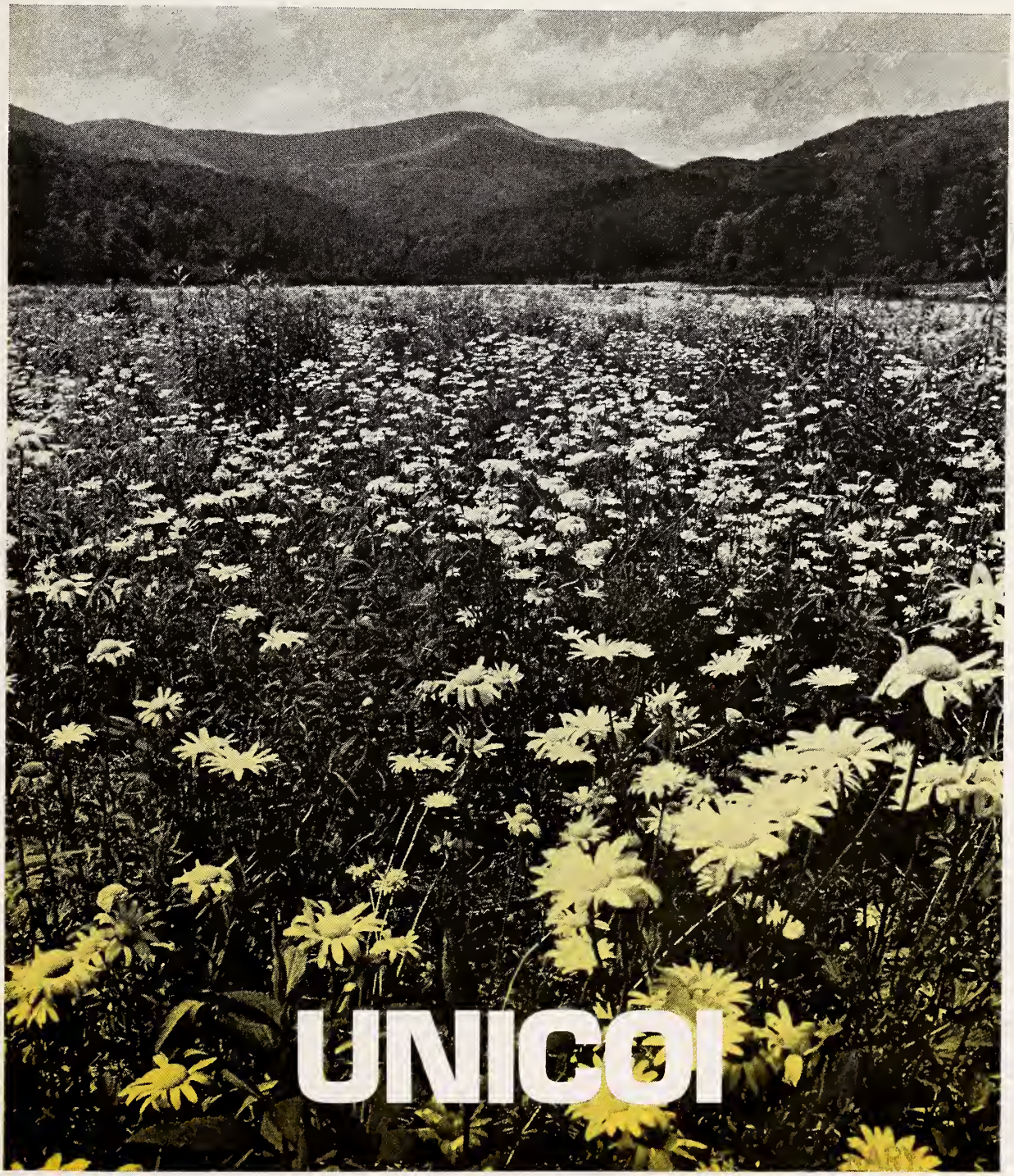
The Diabetes Unit of Emory University School of Medicine and the Georgia Department of Human Resources present:

Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications

This is an on-going course of instruction for physicians who are interested in a comprehensive review of up-to-date methods of managing diabetes mellitus. The course will be offered on a Tuesday or Thursday each week for 10 weeks. The first session will begin October 1 and October 3, 1974. There is no tuition fee. The course is approved for 50 hours of postgraduate work by the Georgia Academy of Family Physicians.

Those interested in registering for the course should contact: Dr. John K. Davidson, Diabetes Unit, Emory University School of Medicine, 69 Butler Street, S.E., Atlanta, Georgia 30303. Phone (404) 659-1212, Ext. 797, and ask for Mrs. Alogna.

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"A stronger, more cohesive MAG"

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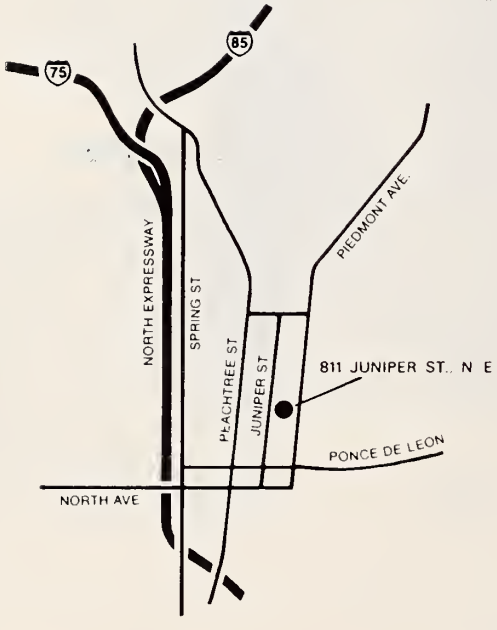
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THE COVER

The tranquil beauty of the north Georgia mountain retreat, Unicoi, should provide inspiration to MAG leaders as they gather there in October to examine the Association and the way it operates. J. Rhodes Haverty, M.D. reviews the purposes of the Unicoi meeting in his President's Letter on page 379.



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An encouraging up-to-date review of the position of this therapeutic tool.

Radiotherapy of Carcinoma of the Cervix

H. E. BRIZEL, M.D., ARLIE E. FIVEASH, M.D. *and* JERRY W. HOWINGTON, M.D., *Augusta**

CANCER OF THE CERVIX was one of the first malignancies to be successfully treated with irradiation. However, when the lesion had spread beyond the site of origin, the survival rate tended to drop precipitously with higher morbidity and complications.[1-3] It is the purpose of this paper to review the position of radiation therapy for carcinoma of the cervix. It will discuss survival, treatment techniques, side effects and complications, as well as some newer approaches.

One hundred eighty-five cases of cervical cancer were seen in the Division of Radiation Oncology at the Medical College of Georgia from 1960-1970. One hundred twenty-four completed a course of radical treatment for stages I through III and will be analyzed in detail. The remainder of the patients included those who were incompletely treated because of poor general condition and also those treated postoperatively after a Wertheim hysterectomy and node dissection, and after a Schaute procedure. Another group was treated only for palliation and recurrent disease. Of the 15 stage IV patients, only six completed treatment and these will not be considered further. Except for six adenocarcinomas, all lesions were squamous cell with varying degrees of differentiation. The median age in all stages was 54 years. There were 35 stage I cases, 54 stage II cases, and 35 stage III cases.

Treatment Techniques

All patients were treated with combinations of intracavitary radium, 2 MeV or 4 MeV external beam, or transvaginal orthovoltage. With very few exceptions, all of the intracavitary treatments were performed using either the Manchester rubber tandem and ovoids or the Fletcher-Suit, semi-fixed, metal applicator. Proper positioning of the applicators was established by bi-plane radiographs. Bladder and rectal doses were frequently measured using a scintillation detector.[4] Doses in roentgens were also calculated to points A and B (vida infra). In all cases, the intracavity dose was also expressed in milligram hours.

All patients received some form of external beam therapy, either to the entire pelvis or lateral walls only. The sequence of external beam therapy and intracavitary radium was individualized regardless of stage. Whole pelvic irradiation to both the parametria and midline areas usually preceded the first radium application in bulky lesions. Fractionation was administered at the rate of 1,000 rads per week with five fractions per week. As staging or the size of the lesion increased, more emphasis was placed on whole pelvic irradiation with average tumor doses of 6,000 rads in stage III where disease was extensive in the parametrial regions, involving one or both pelvic walls, or the lower third of the vagina. Fifty per cent of stage I, 65 per cent of stage II, and 90 per cent of stage III patients received some whole pelvic, external beam irradiation during the course of therapy. Because of the higher external beam contribution, most stage III patients received only one radium insertion whereas in stage I, one-third received more than two insertions.

The staging classification is that of the American College of Obstetricians and Gynecologists[5] (Table 1). A staging system should be of value in formulat-

* From the Division of Radiation Oncology, Medical College of Georgia, Augusta, Georgia 30902 and Augusta Radiation Center. Read in part before the section on radiology of the 119th Annual Session Business Meeting of the Medical Association of Georgia in Augusta May 12, 1973. Dr. Howington is a Clinical Fellow of the American Cancer Society.

ing proper treatment techniques, and also in evaluation and comparison of results from one center to another. The specific drawbacks in the present ACOG classification will be discussed, as well as methodology for increasing the accuracy of staging.

All patients had at least a three year follow-up and all deaths were considered due to cancer even in those situations where intercurrent disease was felt to play a significant role. Although several patients died after five years, there is no statistically significant difference in mortality between three and five years in this present series. The three year, disease-free survival in stage I was 75 per cent, in stage II, the overall disease-free survival was 69 per cent, and in stage III, 46 per cent (Table 2). The stage I survival percentage is slightly lower than reported in some centers and this will be commented upon subsequently.

Cesium 137, Afterloading Techniques

Cesium 137 sealed sources have replaced radium for gynecologic use since 1970. With over 260 applications having been performed, the following conclusions have been reached: (1) The immediate tumor response is identical to that of radium. (2) Tolerance of normal pelvic tissues is also the same. (3) The dose distribution within the pelvis using identical applicators is very similar to that from radium, probably because the average energy of both isotopes is similar.[6] (4) Radiation safety is enhanced because the cesium is encapsulated in solid, ceramic microspheres so that breakage is less of a problem compared to the hazard from radon gas and radium salt.[7] (5) Because of the 660 KV gamma ray from cesium, shielding is possible in the operating room (if afterloading is not used). (6) Bedside shielding is quite practical.

Since 1969, the Fletcher-Suit afterloading applicators have been employed at this institution[8] (Figure 1). The long rigid tandem allows for rotation of a retroflexed uterus. It also permits more than three tubes in the tandem when the uterus is enlarged. The afterloading aspect itself has contributed to improved applicator geometry inasmuch as there is no rush in the operating room because of radiation exposure. Operating room personnel are more willing to cooperate with the radiotherapist, the patient is not sequestered in a corner of the recovery room, and the radioactive sources can be quickly inserted in the applicator once the patient has returned to the room, and after dosage calculations have been made.

Any therapeutic regimen has to be considered in relation to burden as well as benefits. It is important, however, to distinguish "complications" which may



FIGURE 1A

(A) Fletcher-Suit afterloading applicators. Note the three curvatures on the tandems. The three cesium tubes on the left are inserted in the hollow tandem at the same time as are the single vaginal tubes on the right (one vaginal source is partly inserted in the applicator).

TABLE 1

CERVIX UTERI (Clinical Staging—ACOG)
(Approved 1962)

Stage 0: Pre-invasive carcinoma, so-called carcinoma in-situ.

Stage I: The carcinoma is strictly confined to the cervix (and extension to the corpus is disregarded).

Stage Ia: Cases with minimal stromal invasion (preclinical invasive carcinoma, i.e. cases which cannot be diagnosed by routine clinical examination).

Stage Ib: All other cases of Stage I.

Stage II: The carcinoma extends beyond the cervix, but has not extended onto the pelvic wall. The carcinoma involves the vagina, but not the lower third.

Stage IIa: The carcinoma has not infiltrated the parametrium.

Stage IIb: The carcinoma has infiltrated the parametrium.

Stage III: The carcinoma has extended onto the pelvic wall. On rectal examination there is no cancer-free space between the tumor and the pelvic wall. The carcinoma involves the lower third of the vagina.

Stage IV: The carcinoma has extended beyond the true pelvis or has involved the mucosa of the bladder or the rectum. However, the presence of bullous edema is not sufficient evidence to classify a case as Stage IV.

TABLE 2

CARCINOMA OF THE CERVIX 1960-1970
Survival Data—Uncorrected for I.D.*

	3 Years No. Patients	%	5 Years No. Patients	%
Stage I	26/35	75	21/28	75
Stage II	38/54	70	31/46	67
Stage III	16/36	46	12/24	50

*** Deaths due to intercurrent disease.**

be permanently distressing to the patient, which may require additional therapy for correction, and which may outweigh therapeutic benefit—from "side effects" which are either self-limited or of little consequence ultimately. Most of the patients in this series experienced varying degrees of abdominal cramping, nausea, and diarrhea, either during the course of treatment or within the first week or two thereafter. Except in several cases, this responded to medication or brief interruption of treatment. Cystitis during and after therapy was a minor problem, occurring in only a few cases.

Especially in stages IIB and III, most examiners observed varying degrees of pelvic fibrosis within two years after therapy. Inasmuch as this was found in most patients who received high external beam irradiation, and since this was generally asymptomatic, this was scored as a side effect. The most distressing side effect was the high incidence of vaginal stenosis. It was usually noted within two years of the completion of treatment and was most extensive in elderly patients who were sexually inactive and in those patients with more advanced central disease. This situation can probably be largely avoided by patient education, early and continued dilatation after treatment, and vaginal hygiene using topical estrogens.[9]

The incidence of true complications is considered acceptable.[10, 11] Four patients developed rectovaginal fistulas, two in stage I and two in stage III. Both had persistent disease at the time of diagnosis. There were five patients who developed rectosigmoid stenosis, four of which did not require surgical intervention and which were managed symptomatically. One additional patient had recurring episodes of proctitis with attendant blood loss requiring intermittent transfusions. Lastly, one patient had a fracture through the femoral neck, attributable to radiation through lateral fields.

Discussion

A. Clinical Staging—A compromise must necessarily be made between the over-complexity of subdividing disease extent to cover all situations and that in which the categories are so overly simplified as to overlook certain critical variations in presentation which will affect not only treatment but prognosis. None of the three staging classifications has been entirely perfect. The League of Nations system has been replaced by the ACOG classification, which is probably too simplified, and by the TNM system, which is overly complex and impractical for carcinoma of the cervix.[2, 3, 12, 13] The ACOG system is too broad in stage I, encompassing all lesions from minimal stromal invasion involving a small area of one cervical lip to the very infiltrating and extensive lesion involving the entire cervix and the uterine corpus. Although the surgical approach in stage I may be unaltered when there is a large cervical lesion involving the lower uterine segment, the sequence and quantity of intracavitary irradiation and external beam therapy is markedly affected. Likewise, treatment planning as well as prognosis significantly change from a stage IIB (ACOG) which has minimally infiltrated one or both parametria to the situation where both parametria are massively involved, although the pelvic wall may still be free to digital examination. A recent M. D. Anderson

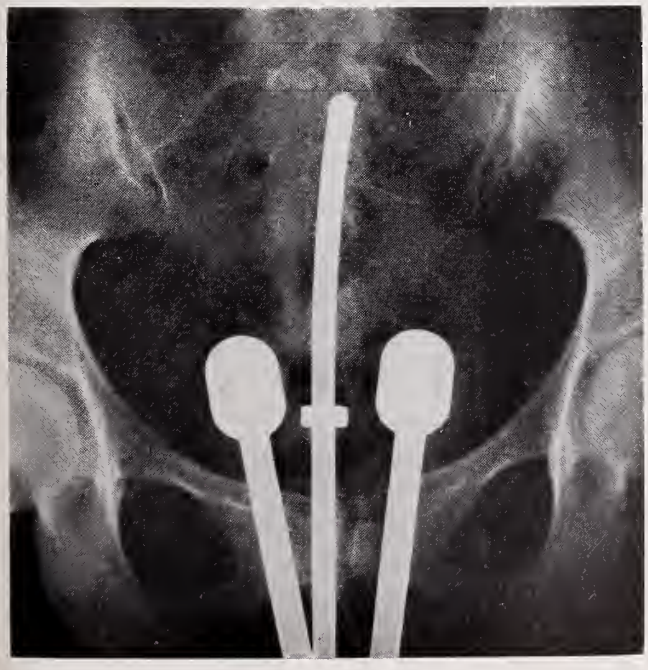




FIGURE 1B, 1C

(B) Anterior and (C) lateral radiographs showing good positioning. The tandem is high in the pelvis, in an anterior position, and midline to both pelvic walls. The vaginal sources are positioned perpendicular to the axis of the tandem, symmetrically over the cervix, and at the level of the acetabula.



FIGURE 2

Pelvic radiation distribution in single plane from tandem and ovoids. Computer readout is superimposed over actual applicator radiograph. Rads per hour are indicated in table to correlate with isodose lines.

modification of the League of Nations staging system is much more practical in that it takes into account the *degree* of involvement of the cervix, possible uterine spread, and the extent of parametrial involvement.[14]

B. Further Analysis of Stage I Patients—Statistical error (due to small sample size) could account for the apparent failure rate of 25 per cent in Stage I being somewhat higher than that observed in some institutions. However, other factors are of interest. In nine of the 35 cases, at least one senior examiner described a lesion which was possibly understaged on the basis of involvement of a vaginal fornix or shortening, thickening, or nodularity in the parametrium. Also, 16 of the 35 stage I cases had either the cervix completely replaced by neoplasm or presented with extension of disease into the body of the uterus as evidenced by fractional curettage. Finally, the general medical condition of the patients was evaluated and it was noted that 13 had severe medical problems such as hypertensive cardiovascular disease, diabetes, severe obesity, and cachexia. Overall, 26 of the 35 patients had either questionable staging, a large, unfavorable lesion, or were in poor medical condition.

Twenty-four patients received radical hysterectomies, with and without node dissections, for stage I disease during the same period. As a contrast, to illustrate the problems faced by the radiotherapy group, the median age in the surgical series was only 34 years as compared to 54 years in the irradiated group. Only one of 24 patients was considered a poor surgical risk. Questionable staging existed in only three and most of the cervical disease was described as no greater than two or three centimeters in maximum dimension. Interestingly, the three-year survival in this group was 83 per cent as compared to 75 per cent in the irradiated group. Statistically, this difference is not significant ($p = 0.42$).

C. Dosimetry—Regarding intracavitary dosimetry, careful attention was given to the standardization of the ratio of radium loading between tandem and ovoids, proper height of the entire applicator system within the pelvis, as well as to proper positioning of the tandem and ovoids relative to one another. Additionally, dosimetry was expressed as "milligram hours" with a generally constant total radium distribution depending on the applicator, and for a specific amount of time—two to three days—dependent upon the preceding amount of external irradiation or that planned subsequently. Dosage calculations in roentgens to points A and B were done as a secondary procedure, primarily beneficial in those few cases where corrective, asymmetrical external irradiation might be necessary. Point A is located 2 cm. from the end of the lower uterine radium source and

2 cm. laterally in the frontal plane. It is actually not a "point" but a *critical region* in which the dose rate from the central source can vary by a factor of two within a distance of less than 1 cm.[16] Not only has point A been shown not to be a true anatomical structure, but there has been a singular lack of correlation between dose to point A, local cure rates, and bladder or rectal complications.[4, 17] Point A can shift markedly because of (1) various normal anatomical differences between patients, (2) bulky central disease distorting the pelvic structures and displacing the applicator in various directions, and (3) inadequate packing of the applicator to insure proper symmetry and height in the pelvis, especially when the cervix and uterus are very mobile. If the tandem and ovoids are poorly positioned relative to one another, such that the radium in the ovoids lies anterior or posterior to the axis of the tandem, there can be a significant dose gradient across the cervix resulting in either necrosis, inadequate tumor dose, or combinations of these undesirable factors. This unfortunate situation can exist in spite of apparent adequate dose to points A and B bilaterally. Finally, if the tandem is too low in the pelvis, regardless of the dose calculations to points A and B, the dose to the common iliac lymph nodes is significantly reduced.[15]

During the last year, a specialized radiotherapy computer has been in use on selected cases where applicator positioning has not been ideal. Dose gradients throughout the pelvis in several planes can be evaluated quickly and accurately without the pitfalls of using one or two points in a three-dimensional system (Figure 2). ■

The authors would like to express their appreciation to Mrs. Frances Hamilton, R.T., for her assistance in the preparation of this manuscript.

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THE MOST EFFECTIVE PUBLIC RELATIONS—GENUINE CONCERN

An Atlanta physician received this note of thanks from an out-of-town newspaper editor who found it a refreshing personal experience to observe the dedication the medical profession exhibits.

Dear Doctor:

It was your day off. You customarily don't make house calls. Yet you graciously took the time to come to our hotel room and see my wife.

You were diplomatic and obviously highly competent, and your good counsel eased our fears and apprehension about the blood clot in her leg.

Our trip home was uneventful and comfortable for Mrs. C. Northwest Airlines personnel were most helpful in providing us seats where she could have her leg elevated. They also arranged for wheel-chair service in Atlanta and Spokane.

When we reached home, we contacted our physician, who as I mentioned is a long-time personal friend of ours. Mrs. C. will be "grounded" for a time, but she should get along well, thanks in large measure to your diagnosis and advice. We will be forever grateful to you.

A newspaperman by training is skeptical of things and people, but he should never be cynical. It's a good tonic for a hard-nosed editor and an antidote for cynicism to encounter, in a strange city, the genuine compassion and kindness you showed to us.

I'm enclosing a small token of our appreciation and I hope that if ever you come to Spokane you will be certain to call me.

Sincerely,
H.C.C.
Managing Editor

With correct diagnosis and management, it should be the rule, not the exception, that the injured knee achieves a functional recovery.

The Injured Knee

JACK C. HUGHSTON, M.D., JAMES R. ANDREWS, M.D. *and* MERVYN J. CROSS, M.B.B.S., F.R.A.C.S., *Columbus**

THE ACUTELY INJURED KNEE is a paradox in that the severely painful, swollen and locked knee often proves to be less serious than the sore and non-swollen one. Excluding fractures, three types of knee injury constitute about 95 per cent of the cases; these are meniscus tears, patella subluxation and torn ligaments. Clinically, these three specific disorders of the knee can be well differentiated. This is vital as the management of each is different.

Meniscus Tears

The torn meniscus is the most common cause of an acute knee disorder. The mechanism of injury may seem insignificant. There may be pain on arising from a squatting position after throwing a railroad switch, twisting the flexed knee when stepping up on the ladder of a railroad car, or suddenly changing direction when running. The usual history relates to pain and limp at the time of the injury, but ability to continue on the job. Within 12 to 24 hours, considerable swelling and pain often occur with associated inability to straighten out the knee (locked) and difficulty in walking. Then the patient seeks medical attention. Examination at this time demonstrates a swollen knee, tender all over, but may be more tender over the medial joint line. Motion is limited. The pain is aggravated on attempts to force extension or flexion to the normal limits. At this time a definite diagnosis can rarely be made.

Management consists of non-weight bearing with the aid of crutches, and progressive resistance exercises for the quadriceps. These exercises pump the fluid out of the joint, reduce the pain and tenderness, and gradually overcome the hamstring muscle spasm so that a more normal range of painless motion results. This knee should be re-evaluated at least each week. Resolution of the acute episode usually occurs within one or two weeks so that absence of generalized tenderness, swelling and limited motion allows a more precise clinical evaluation. We see about 50 knee cases per week, and an average of 10 fit this clinical picture; of these ten, 50 per cent recover and return to work or sports within two to four weeks. Therefore, a locked, swollen knee is not an indication for operation, until the acute episode has subsided sufficiently to allow a definite *objective* diagnosis of a torn meniscus.

The above description primarily fits the torn medial meniscus; a torn lateral meniscus may result in minimal swelling and only a nagging pain with the patient able to continue on the job or in his sport with soreness increasing with activity and subsiding with rest. However, inspection of the flexed knee (the patient supine with the foot resting on the examining table and the knees flexed 80 to 90 degrees) may show a mild degree of comparable swelling over the lateral joint line (Figure 1). Palpation at this point of localized swelling will produce pain. Most Orthopaedic Reviews have indicated the lateral meniscus to be infrequently torn. This has not been our experience. Smillie,[11] of England, reports an incidence of 28 per cent; American literature[1] reports indicate an average incidence of lateral meniscus tear of 16 per cent. We (Andrews and Hughston)[8] reported an incidence of 35 per cent lateral meniscus tears. Further, we demonstrated an incidence of 15 per cent bilateral tears, that is a tear of both the medial and the lateral meniscus. Smillie[12] reported

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FIGURE 1

Swelling over the right lateral meniscus is oedematous tissue rather than a meniscal cyst and indicative of a possible tear of the lateral meniscus.

an incidence of five per cent combined medial and lateral meniscus tears. As our relatively high incidence of tears of both menisci would indicate, we feel the lack of recognition of a tear of both the medial and lateral meniscus may explain many of the poor results of meniscectomy, with one torn meniscus remaining in the joint.

The progressive resistance exercise for the quadriceps muscle are done with the patient sitting on the "kitchen table," a weight on the ankle or foot, and a folded towel under the thigh at the edge of the table (Figure 2). The towel makes the thigh parallel to the floor, and protects the hamstring tendons from contusion by the sharp edge of the table. In this position the leg is extended so it is straightened as far as possible 10 times, resting a second between each ten contractions until he has built up to doing eight repetitions of 10 on at least three separate occasions each day; a total of at least 240 leg lifts per day. We feel that many repetitions are much more important for recovery than a few lifts of a large amount of weight. We generally start the patient lifting two to three pounds of weight. Over the next few days or weeks, he gradually builds up to 15 or 20 pounds. The repeated quadriceps contractions pump the synovial pouch, just like milking a cow, gradually resulting in reabsorption of the fluid. We feel that it is important not to aspirate the acute joint as it lends nothing to diagnosis. Immediate swelling indicates hemarthrosis; whereas effusion 12 to 24 hours after the injury is consistent with synovial fluid exudation. When aspirated, the effusion frequently recurs within the next 24 hours following aspiration and causes the patient to be looking forward to repeated aspirations for comfort, rather than his learning the importance of the quadriceps exercises in reducing the swelling and restoring the knee function. Aspiration may also result in a septic joint.

Patella Sublaxation and Dislocation

The second most common cause of an acute knee injury is a subluxation or dislocation of the patella. Medical text books and literature for 60 years or more followed Goldthwait's[3] statement: "The above condition is seen almost entirely in girls or women." In 1964, we reported its high incidence in male athletes,[9] and more recent review of our cases in 1972,[7] showed an overall occurrence of 48 per cent males and 52 per cent females, but a 62 per cent occurrence in males in the more active age group of 15 to 22 years.

The subluxating or recurrent dislocating patella is easily confused with the clinical picture of a torn meniscus. Unfortunately, we not infrequently see a patient continuing to have giving away, locking, popping, swelling, etc., following a meniscectomy; and objective examination reveals a subluxating patella. The patellofemoral joint must always be evaluated in cases of internal derangement of the knee.

The mechanism of injury in subluxation or dislocation of the patella may be the same as the meniscus, that is coming up out of a squat and simultaneously pivoting or twisting off the weight bearing leg. More often, this occurs when the body has a greater momentum, such as running and then cutting in the opposite direction, or jumping off a moving car and twisting on the weight bearing leg. The knee gives way with pain and automatically the patient straightens his leg and the patella spontaneously reduces without his ever having known that it was dislocated. Only 12 per cent of our 400 cases of this disorder have ever seen or known their patella to have dislocated.

Immediately following the acute episode the patient may have minimal discomfort, but he tends to walk with a straight knee gait rather than the bent knee gait of a meniscus injury. If the patella chipped

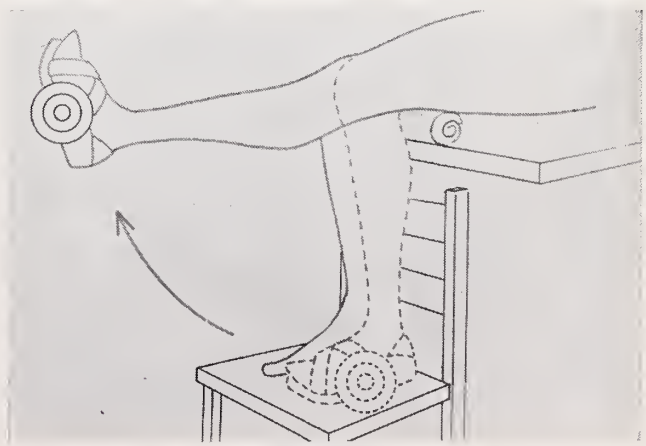


FIGURE 2

Progressive resistance exercises for the quadriceps muscle. The towel protects the skin as well as elevating the thigh. The chair prevents gravity from distracting the ligaments.

off a piece of bone in dislocating out of, or back into, the patellofemoral groove, then the swelling will likely occur to a maximum degree within two hours of the injury. Maximum swelling within two hours of the injury is a hemarthrosis in contradistinction to the synovial effusion occurring in 12 to 24 hours after a meniscial injury. Again we do not aspirate this joint; we know it is blood because of the rapid swelling; and if the bleeding is not stopped the joint will only fill again following aspiration. This hemarthrosis can be reabsorbed by exercise, the same as the synovial effusion. However, in cases of patella subluxation or dislocation, the patient can rarely exercise from flexion to extension due to the pain resulting from the excursion of the patella on the femoral condyles. The progressive resistance exercises for the quadriceps are done by means of repeated straight leg raising up to 60 degrees with the patient lying supine (Figure 3). In the acute case with hemarthrosis, we generally immobilized the leg in the cylinder plaster with the knee in extension, for comfort as well as for speeding recovery, ambulate him with partial weight bearing with the aid of crutches and instruct him in doing eight repetitions of 10 progressive resistance exercises three times a day in the cast, contracting the quadriceps each time and not relying on the hip flexors to lift the immobilized extremity.

Let us return to the patella that has slipped and did not produce a hemarthrosis. This knee may swell 12 to 24 hours following injury due to effusion. If so, the degree of effusion is usually mild. More often, there is no post-traumatic swelling. But, the knee may remain sore and continue to suddenly give away, pop, hurt on going up and down stairs, and pain on twisting and pivoting. Examination will reveal tenderness along the medial aspect of the joint, tenderness over the medial edge of the patella, pain on forcing the patella against the femoral condyles with the knee in extension, and pain and apprehension on attempting to passively displace the patella laterally with the knee flexed 45 degrees (Figure 4).

Knee examination should always include evaluation of the uninjured knee in comparison to the injured. The knee should always be evaluated in a flexed position with the legs hanging loosely off the examining table; here you may note a lateral posture to the patella, or high riding patella (Figure 5). If the knee is then held in partial extension, resisting gravity, a vastus medialis dysplasia may become apparent (Figure 6). Both these signs indicate the possibility of a patella subluxation.

Treatment of the subluxating patella, primarily consists of bandaging, elastic support and progressive resistance exercises of the quadriceps with the knee in extension. Failure of this conservative regime indicates operation which has only been performed on 150 out of 500 cases thus far seen.[5] When operative correction is necessary, patellectomy is rarely indicated. Functional recovery is much better with shaving the patella and correcting the extensor mechanism. Our report[7] showed 34 out of 58 male athletes, having operative correction, returned to their sports at their pre-injury functional level.



FIGURE 3

Progressive resistance exercises for the quadriceps with the knee in extension, used in cases of patellofemoral disorder. Note the opposite hip and knee flexed to decrease lumbar lordosis. Straight leg raising with weight is performed to approximately 60 degrees.



FIGURE 4

Lateral pressure on the medial aspect of the patella tests the stability of the patellofemoral joint at 45 degrees knee flexion. (Reprinted from "Subluxation of the Patella" by J. C. Hughston, M.D., J. Bone Joint Surg. 50-A:1003-1026, July 1968).

This high incidence of resumption of athletic participation gives some insight into the ability of the knee to recover following this rather extensive surgical reconstruction.

Knee Ligament Injury

Knee ligament injury is the third most frequent acute traumatic knee disorder. These ligament injuries are divided into mild (1+), moderate (2+), and severe (3+) sprains of the ligaments. Grades I and II are mild and moderate sprains or incomplete tears and recover well on conservative treatment of supportive measures and exercises. Grade III are severe sprains or complete tears, and some of these require surgical treatment. When surgical repair is indicated, ligament tears differ from meniscus injury and patella subluxation in that the optimal time for operative repair is within the first week following injury. This golden period of healing may be missed, because oddly, the more severe the tear, the less the pain and swelling. The athlete, or worker, most often comes in for examination, walking unaided with barely a limp, having taken nothing more than an aspirin for pain, and showing little to no swelling (effusion) or limitation of motion. He comes in because the knee is sore, he cannot run, cut or jump, and the knee tends to go out from under him on pivoting or twisting. He has no pain because the rupture is complete. If it is incomplete (a mild to moderate sprain), he usually has considerable pain and limited motion. The patient with the complete tear can walk because of the kinetic support afforded by the muscle units crossing the knee holding the hinge type joint surfaces opposed. Seventy-five of 100 consecutive operative cases demonstrated no intra-articular swelling clinically, or at operation, because the rupture was complete and allowed extravasation of the joint fluid and hemorrhage into the surrounding tissues. These patients could not run, cut, twist, or jump and land on the involved extremity because the torsional (rotational) stresses would overcome the muscle support and cause the leg to give away.



FIGURE 5

This silhouette view demonstrates high patella posture, which we term patella alta.



FIGURE 6

Note the hollows on the medial aspect of the distal thigh due to dysplasia of the vastus medialis obliquus muscles. (Reprinted from "Subluxation of the Patella" by J. C. Hughston, M.D., J. Bone Joint Surg. 50-A:1003-1026, July 1968.)

The stability of the collateral ligaments of the knee is tested by the abduction and adduction stress tests (Figure 7). The uninjured leg is always examined first for comparison and to show the patient how you will be examining the injured knee, thus reducing his fears. If the knee fits into that 25 per cent having swelling, pain and limitation of motion, the stability can still be evaluated by examination with gentleness and finesse.

The anterior and posterior drawer test is often painful and we rarely use it as a criteria in the acute knee (Figure 8). The drawer test does not, in our opinion, evaluate the integrity of the anterior cruciate ligament.[6] Also, in reports in 1961 and 1962,[4] we showed evidence that an isolated tear of the anterior cruciate ligament did not result in functional instability of the knee and that it did not need surgical repair. The additional years of experience since that report has not shown just cause to change our opinion. Reports of others[2, 10] are to the contrary, recommending surgical repair of the isolated tears of the anterior cruciate ligament. We hold hard that these anterior cruciate ligament tears do not justify operative intervention and we know of no documented evidence proving that a repair of these mop end tears of this intra-articular ligament heals with restoration of normal function of this ligament. In ligamentous injury, the collateral ligaments are the real problem.

If the instability is severe, operative repair is indicated within the first week.

It is impossible to relate in writing the judgment regarding moderate instability and its need of operative versus conservative treatment. Prior to the last few years, we treated the mild instabilities by plaster immobilization for six weeks. These frequently demonstrated a persistence of this same mild instability at the time of discontinuation of the immobilization, and at further follow-up. We looked for a more effective way of treating the mild instabilities conservatively. We found these recover, usually returning to normal stability, by placing them on crutch ambulation with absolutely no weight bearing on the injured extremity for three to four weeks and dedicated progressive resistance exercises for the quadriceps of the type described for the meniscus injuries.

Injury to the lateral collateral ligament is more difficult to evaluate clinically than the medial ligament looseness. Some of this difficulty is due to the normal mild looseness of the lateral side of the knee joint. In addition to the adduction stress test, the rotational recurvatum test may be more revealing regarding the tear of the posterolateral ligaments. This is performed by having the patient supine and lifting the uninjured extremity by the foot and noting the degree of sag (recurvatum) at the knee and noting the amount of external rotation of the proximal tibia in the last few degrees of the extension (Figure 9). Then, compare this with a test on the injured extremity. Even a mild excess of recurvatum and external rotation is indicative of possibly a severe tear of the posterolateral ligaments. Sometimes the patient can actively demonstrate this recurvatum in the acute stage by standing and, simultaneously, extending his knees as far as possible. If the injured knee goes into a comparative excess of recurvatum with a mild increasing discomfort on the back and outside of the knee, then it may indicate a tear. Also, the patient is moderately tender to palpation over the posterolateral ligaments. This rotational recurvatum sign is often subtle, but when present, it is significant. A mild posterolateral instability recovers poorly on conservative treatment and may gradually increase in the following months. This becomes understandable when you realize how we walk, and even stand, with an excess of stress on the back and outside of the knee.

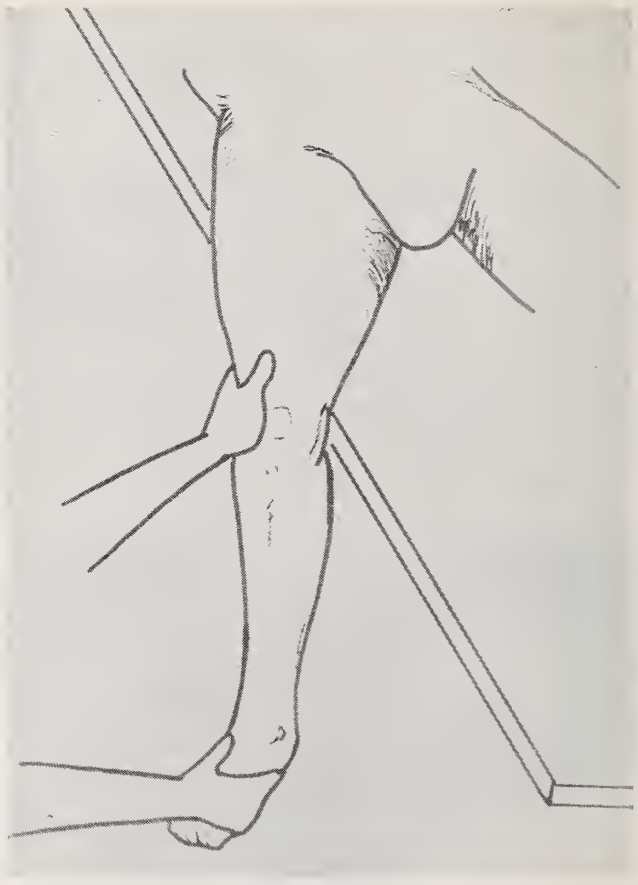


FIGURE 7

Abduction Stress Test. The top portion of the illustration demonstrates the knee flexed at 30 degrees. It is extremely important to have the knee flexed in this manner while carrying out the abduction stress test in order to relax the posterior capsule and posterior cruciate ligament. If the knee is tested in extension, even if the medial ligaments and the anterior cruciate ligament are torn, one would be unable to elicit a sign of instability because of the tautness of the posterior cruciate ligament and the posterior capsule. With the knee in a moderate degree of flexion, the posterior capsule is relaxed, and a lack of continuity of the ligaments about the medial aspect of the knee joint will allow a sensation of a giving away of the inside of the knee joint on carrying out this test. The lower illustration shows the proper placement of the hands, the one hand being placed at the outside of the knee joint or just proximal to the knee, while the other hand is placed about the inside of the mid or lower third of the leg. The hand at the knee joint forces the thigh toward the center line of the body while the hand about the leg pulls away from the center line of the body. (Reprinted from "Knee Ligament Injury in Athletes" by J. C. Hughston, M.D., JMAA 36:1-9, September 1966.)

Post-Operative Care

In those knees necessitating operative correction, the post-operative management is almost as important as the adequate surgical correction. This post-operative management requires frequent patient-physician communication, much physician persistence, and a long follow-up. This is often tiring, and sometimes an apparent deficit of patient co-operation is discouraging, but never giving up is most often rewarding. Dedicated physical therapists and athletic trainers can aid in this post-operative care, but unfortunately, they cannot substitute for the surgeon's interest, impact and responsibility.

Summary

Three types of knee disorder constitute the large majority of acute injuries. The meniscus tears are the most common, followed by patella subluxation and dislocation, then by ligamentous injury. The

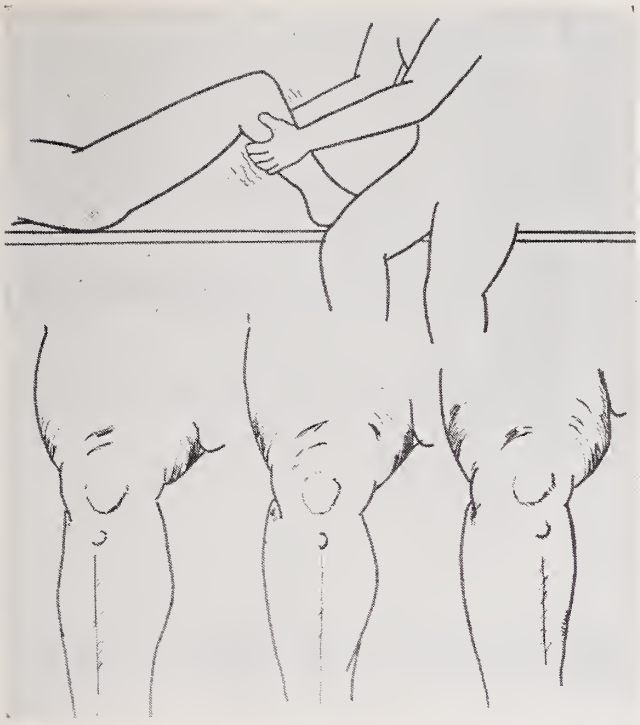


FIGURE 8

Anterior Drawer Test. The patient is placed in a supine position, the hip flexed 45 degrees, the knee flexed approximately 90 degrees. The examiner sitting on the dorsum of the foot of the leg being examined, grasps the leg just below the knee and exerts a repetitious pull and push motion. (This repetitious motion also helps to produce a relaxation of the hamstrings.) The position of rotation of the tibia is very important in the carrying out of this test. If the tibia is held internally rotated (A), the ligaments can be torn and there will be no positive anterior drawer sign. With the tibia in a neutral position (B), the ligaments can be torn, and there will be a mild to moderate anterior drawer sign. With the tibia fixed in a slightly externally rotated position (C), the maximum amount of instability can be demonstrated with a resultant severely positive anterior drawer sign, because with the tibia externally rotated, the posterior cruciate ligament is in its most relaxed position. (Reprinted from "Knee Ligament Injury in Athletes" by J. C. Hughston, M.D., JMAA 36:1-9, September 1966.)



FIGURE 9

External rotational recurvatum test: note the abnormal external rotation, recurvatum, and varus of the involved right knee compared to the normal left knee.

diagnosis of each of these is clinical, though x-ray may sometimes be helpful. Arthrograms are sometimes indicated as an adjunct to diagnosis of meniscus injury. Arthroscopy is used by some orthopaedists as an additional diagnostic tool, but we feel insertion of this scope into the knee joint is comparable in operating room time, anesthesia and joint trauma to a surgical arthrotomy. We do not operate on a knee without clinical objective evidence of the necessity of operation and thus in our hands we would not be carrying out an arthroscopic examination unless we similarly felt an operation was definitely necessary.

It is our experience that at least half of the acute knee problems compatible with a meniscus tear recover on conservative treatment; that more than half of the acute subluxating or dislocating patellae, recover conservatively, that the mild ligament tears regain stability with conservative treatment; that so-called isolated anterior cruciate ligament tears do not justify surgery; and that severe acute collateral ligament tears need operative repair within the first week.

If surgical correction of an injured knee does prove to be necessary, it is most important that the initial surgical intervention be carried out on the basis of a sound pre-operative diagnosis and that pathology be corrected to the best possible advantage at the initial operation. Second, third and fourth surgical attacks have a decreasing percentage incidence of excellent recovery.

Conclusions

The acutely injured knee can be evaluated clinically. Only those cases of acute severe ligamentous instability indicate surgical repair within the first week following injury. The apparent meniscus injury and patella subluxation deserve conservative treatment and follow-up until there is definite objective evidence of disorders sufficient to indicate surgical correction; these are not surgical emergencies. The injured knee should not be operated on just because it is swollen and locked. Locking is due to hamstrings spasm; rarely, to interposition of a torn meniscus. Once a meniscus is objectively determined to be torn, or a patella subluxating sufficiently to produce joint deterioration operative correction is indicated in order to help prevent secondary joint injury, deterioration and arthritic proliferation. With correct diagnosis and management it should be the rule, not the exception, that the injured knee achieves a functional recovery.

It is obvious from this text that much of the diagnosis and management of the acutely injured knee can be intelligently performed by the patient's family physician. But this necessitates often repeated

evaluation and persistence in very positive management. ■

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Highlights of Executive Committee of Council

August 11, 1974

Appointments: *Ad Hoc Committee to Evaluate Peer Review Mechanisms,* John R. McCain, M.D., Atlanta, Chairman; *Ad Hoc Committee to Investigate Need for Research and Development Component for MAG;* J. Rhodes Haverty, M.D., Atlanta, Earnest C. Atkins, M.D., Atlanta and Carson B. Burgstiner, M.D., Savannah; *Committee on EMCRO,* Roy W. Vandiver, M.D., Atlanta.

October 5, 6 "Big Think" Meeting: Approved plans for a planning workshop to study issues of organization and operation and to develop concrete alternatives for consideration by the appropriate governing body.

PSRO Repeal Program: Heard a report on responses to the letter mailed to MAG delegates regarding their opinions of the recent action of the AMA House of Delegates and the May 1974 action of the MAG House on PSRO. A complete report is to be made at the September Council meeting.

Georgia Medical Care Foundation: Received information that a new contract had been signed by the Department of Human Resources which provides the only mechanism in the state by which hospitals can provide retrospective review of the Medicaid area; and the announcement of the GMCF Board of Directors meeting August 24-25.

Research and Development: Learned of a site visit by the Cancer Institute. Heard the recommendation that MAG assume the responsibility for an effective medical care evaluation and educational program for Georgia and that it be coordinated with the IMAGE data system, for Council approval in September.

Legislation: Received a report on the status of health planning legislation that would replace Comprehensive Health Planning and the Regional Medical Program. Other provisions include: mandatory certificate of need type legislation at the state level; creation of health systems areas throughout the country with a majority lay board to govern each area. Voted to express opposition to the Congressional delegation.

Credit Bureau Procedures and Forms Used on Behalf of the Insurance Carrier: Heard of an investigation by the Committee on Private Practice regarding checking of medical history of prospective policy holders when applying for coverage. Recommend all-member mailing concerning the results of this investigation.

Foreign Medical Graduates Use of "M.D." After Name: Received for information a report that the Attorney General has requested clarification of the use of "M.D." by foreign medical graduates but took no action as the full report will be made to Council September 21 at the Cloister Hotel, Sea Island.

EMORY RECEIVES AMA CONTINUING EDUCATION ACCREDITATION

Emory University School of Medicine has been notified by the American Medical Association that it has been accredited for continuing medical education for the next four years. This means that all of the postgraduate courses at Emory and all of the weekly programs that are broadcast for television reception are approved by the AMA for Category I credit toward the Physician's Recognition Award. The amount of credit received is on an hour-for-hour basis. Such approved CME is becoming increasingly important to the practicing physician as some states require a minimum of 25 to 50 hours per year of approved CME for relicense. Several of the specialty boards are now requiring their members to take approved postgraduate courses in order to maintain their membership.

The AMA approval also applies to Emory's television tape library. Credit toward the Physician's Recognition Award can be earned on an hour-for-hour basis in Category I when the audiovisual material is being used at a regular medical conference with a speaker who knew the subject in advance and had prepared appropriate remarks. Category 5 credit can also be earned under conditions set forth in the AMA's special bulletin on CME.

Update on MAG Related Programs

CHAMPUS

Civilian Health and Medical Program of the Uniformed Services

The Medical Association of Georgia has had a contract with the Government as fiscal agent for CHAMPUS since its inception in 1956 as the original "Medicare." It was also known for some time as Military Medicare. The name was officially changed after the development of Social Security Medicare to prevent confusion. The original act, the Dependents Medical Care Act of 1956 (Public Law 569, 84th Congress) authorized limited services for spouses and children of active duty service men only. The program expanded in 1966 under Public Law 614, 89th Congress to provide additional benefits to additional beneficiaries.

The program applies to all the seven United States uniformed services: Army, Navy, Air Force, Marine Corps, Coast Guard, The Commission Corps of the Public Health Service, and National Oceanic and Atmospheric Administration (formerly Coast Guard and Geodetic Survey and ESSA). Eligible beneficiaries include: dependent spouses and children of active duty members; retired members; their spouses and children; and spouses and children of the members who died either on active duty or in a retired status. Members of the armed forces of a NATO country who are on duty in the United States and their dependents, when sponsor is stationed in or traveling in the United States in connection with official orders, are also authorized benefits through CHAMPUS. The spouse and children of the 100 per cent, service connected, disabled veteran may be entitled to CHAMPVA. This is a recent program made available through the Veterans Administration. These claims are handled by CHAMPUS the same manner as the retirees with the exception that the disabled veteran, personally, is not entitled to benefits. Determination of eligibility for CHAMPVA is made through the Veterans Administration. For CHAMPUS, eligibility is determined by the military facilities.

CHAMPUS operates under the concept that the patient has freedom of choice in selecting his physician, that the physician is responsible for total care of the patient, and, therefore, that all authorized services normally will be either furnished by the physician or prescribed and rendered by his direction. Coverage for eligible personnel must meet three criteria: (1) be in accordance with good medical practice as defined, if necessary, by local peer review committees; (2) be beneficial to the sponsor; (3) be not excluded by law.

Unauthorized Care

Health care not authorized by law includes: (1) domiciliary and custodial care to assist the patient in the ordinary activities of daily living; (2) physical examination and immunization *not* for diagnosis or treatment, except when required by Uniformed Services orders for travel outside the United States; (3) routine well baby care, except in hospital care of the newborn; (4) ordinary spectacles or examination for the correction of ordinary refractive errors; (5) prosthetic devices, hearing aids and orthopedic footwear except artificial limbs and eyes and orthopedic braces; (6) dental care except that which is *required* in the management of medical or surgical condition other than dental; (8) purchase of durable equipment (authorized only under Program for the Handicapped for active duty personnel); (9) payment for services provided by immediate relatives of the patient; (10) personal comfort items provided by inpatient facility: clothes, kleenex, television, telephone, etc.

Recently limitations have been imposed on payment for psychiatric care. Currently authorized psychiatric care includes 120 days inpatient care plus 40 days out patient visits per fiscal year for each beneficiary.

Physicians and others participate in this program on a voluntary basis. They may refuse to accept a patient under CHAMPUS without stating a reason therefore. Participation means that the provider will: (1) provide the service; (2) submit the signed claim; and (3) accept the amount determined by the Fiscal Administrator to be the *allowable charge* for the services provided as payment in full. There is the right of appeal of these determinations to Fiscal Administrators first and then to OCHAMPUS.

Payments for services are made on the basis of allowable charges which are determined by the fiscal agents administering the program. The criteria considered in determining allowable charges are the customary, prevailing charges and reasonable charges. The term "customary charges" refers to the amount which the individual provider usually and most frequently charges his patients for a specific service in similar medical circumstances. The term "prevailing charge" refers to those charges which are most frequently used in the locality for particular medical procedure or service. Payment normally does not exceed the 90th percentile of the prevailing charge range. "Reasonableness" of variances of the customary/prevailing charge is determined by peer review.

The patient/sponsor is responsible for a portion of authorized charges based on the following: inpatient care; active duty dependent remains responsible for the first $25 or $3.50 per day (which ever is greater) of *hospital bill*. Authorized physician charges paid in full. All other beneficiaries pay 25 per cent. Out patient

care: all beneficiaries pay $50 deductible per one person or $100 for entire family for care provided each fiscal year (1 July through 30 June). After deductible is established, active duty dependents are responsible for 20 per cent, all others for 25 per cent.

All recipients, other than active duty dependents, are *required* to use any insurance available to them through employment or provided by law first and this program second.

Claim Form Suggestions

To insure minimal time and effort by physicians and others in submitting claim forms, instructions have been included on the reverse side of the claim form itself. Forms and additional detailed information are available from this office. We also make the following suggestions: (1) Use the claim form appropriate to the care. For all care by individual providers, other than that provided under the Program for the Handicapped, use 1863-2 (yellow form). The program for the Handicapped uses the 1863-3 (grey), hospital utilize the 1863-1 (blue) and pharmacies use 1863-4 (white). (2) At the earliest practical time after acceptance of the patient instruct the patient or sponsor to complete his portion of the claim form. The claim form which is unsigned by the sponsor or responsible patient or which lacks essential identification information may not be processed for payment. Item #5 presents a particular problem sometimes in that the issue date of the ID card is frequently picked up for the beginning eligibility date. The beginning date is actually on the reverse side of the ID card. All claim forms must be signed, any beneficiary other than an active duty dependent must also indicate on each claim form submitted as to whether or not they have other insurance. These are two items which most frequently cause delay in processing. (3) Complete all remaining items. For coding purposes and determining amounts payable we must know the diagnoses and exactly what services have been provided and when. (4) Do not alter any part of the claim form including the certificate at the bottom of the claim form. We are not authorized to make payment direct to you if this certificate is altered. If you do not choose to sign the claim form give the patient the necessary itemization of your services so that he may be reimbursed. (5) Sign the claim form personally unless you have filed authorization for us to accept the facsimile of stamp or other authorized signatures.

Upon receipt of a properly completed claim form payment can usually be made within three weeks. Because of current increased volume due to the end of the fiscal year, lack of physicians at military facilities, and our personnel vacations, please allow four to six weeks for payment.

CHAMPUS, in Georgia, is the sixth largest of the nation, we currently process approximately 80,000 claims a year with payment to the physicians of nearly $6 million. This does not include hospital charges.

Thank you for your help in making this a viable program. If we can be of assistance to you, at any time, contact us at (404) 875-9505.

Georgia Medical Care Foundation

Professional peer review is the main function of the Georgia Medical Care Foundation, but a number of other benefits deriving from this close association with fiscal intermediaries also accrue to the physicians and people of Georgia. Included among these are a health insurance trouble-shooter function for the provider and patient, and a general accumulation of information relative to the financing and delivery of health care.

The Foundation currently offers professional peer review services in three basic provider areas: In-patient care, ambulatory care, and nursing home care. Some, or all, of these services are currently being utilized by the Georgia Medicaid program, CHAMPUS, Atlanta Blue Shield, and a number of private health insurance carriers.

Hospital Review

In-patient review is currently conducted primarily for the Medicaid program. For the past three years most work in this area has been conducted on a retrospective review basis, meaning that claims for hospital services were reviewed by the Foundation two to six months after the patient was actually discharged from the hospital. The inherent inequity of this system has been recognized by the Foundation for several years, but until this current year little could be done about it. During fiscal year 1975, however, the Foundation is in the process of supplanting this retrospective review system with a concurrent hospital review program called CHEC.

CHEC provides for most of the decisions concerning the medical appropriateness of continued hospital confinement under the Medicaid program to be made within the hospital Utilization Review Committee, with the Foundation Specialty Panels serving only as an appellate mechanism. It is expected that as the year progresses, the CHEC review program will be expanded to cover not only Medicaid, but Medicare and other federally financed patients.

Ambulatory Review

The ambulatory services review capabilities of the Foundation are employed by all health intermediaries, including Medicaid, CHAMPUS, and the others. Claims reviewed under this program number 150,000 a year, and cover all medical specialties. Here review is conducted on a post-service, pre-payment basis to confirm the medical appropriateness of the services delivered.

Nursing Home Review

Nursing home review is a special program developed by the Foundation to aid the State of Georgia in complying with federal regulations concerning the Medicaid program. Under it, three basic types of review are conducted: Pre-admission certification, on-site medical evaluation, and 60-day recertification. Under the pre-

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
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Washington, D.C. 20005

P·M·A

admission program, a facility or physician wishing to admit a patient under the Medicaid program may call the Foundation on its WATS line, supply certain basic medical information concerning the patient they propose to admit, and receive an approval for admission of this patient to skilled or intermediate care. By following the recommendations available through this program, the nursing home is guaranteed that it will be paid for all days that the patient is confined.

On-site medical evaluation involves visitation of each Medicaid patient and each Medicaid nursing home by a team composed of a registered nurse, a social worker, and a local private-practicing physician. This team evaluates the continued need of the patient for a given level of nursing home care, and the ability of that facility to provide the care so needed, and forwards its recommendations to the Georgia Department of Human Resources. The 60-day recertification review is conducted during the on-site visit of the medical evaluation team. In reviewing the medical records of each patient, care is taken to see that each patient in a skilled nursing home has had the required recertification completed by his attending physician.

Other Functions

Due to the closeness with which the Foundation may work with an intermediary in carrying out these review functions, the Foundation is often able to expedite the resolution of problems arising between providers, patients, and the intermediary, or at least obtain an explanation as to why a given action was taken, e.g. late payment, low payment, no payment.

Finally, also due to the nature of the Foundation's work, a good deal of information has been accumulated relative to health maintenance organizations, national health insurance, and health insurance coverages, and is available to all physicians in Georgia.

Should you have questions concerning any aspect of the Georgia Medical Care Foundation operation, the Foundation WATS line is available for use by all physicians, and your call is welcome. The number is 1-800-282-2614.

Georgia Regional Medical Program

The Georgia Regional Medical Program was notified early in July 1974 that a grant award in the amount of $3,648,886 would be received by GRMP for allocation during the funding period ending June 30, 1975.

Representatives of the Division of Regional Medical Programs in Washington have indicated that the Georgia RMP award is the largest grant per capita of any RMP in the nation, and second highest in total dollar amount of the fifty RMPs in the country.

The GRMP Regional Advisory Group met in late July to allocate these grant funds on the basis of program recommendations and proposal reviews undertaken during the past two months by Task Forces and Advisory Committees made up of more than 75 representatives of Georgia medical care and educational institutions, professional groups, and health agencies. More than 150 letters of intent to apply for funds were received from across the state in response to a proposal invitation extended earlier this year.

The awards were made in accordance with program plans adopted by the Regional Advisory Group and approved by the National RMP Council. The program can be divided into three major areas: (1) manpower development and utilization; (2) regionalization of specialized services; (3) improved primary health services.

Manpower Development

In the area of manpower development and utilization, 11 hospitals scattered throughout the state received grants to implement projects in patient and family education. It is felt that organized programs of patient and family education can greatly reduce the time required for these type activities by each physician on the hospital staff.

Since the efficient continuing education of health professionals—particularly doctors and nurses—depends on the identification of what education is needed as well as what effect the education has in correcting any identified deficiencies, a well designed quality assurance program in health care institutions is invaluable. Awards have been made to several institutions to assist health professionals in the further development of acceptable criteria for assessment of quality.

Six of the larger hospitals were given awards to aid them in assisting several smaller surrounding hospitals who requested special help and the Medical Association of Georgia received an award to assist smaller hospitals in the state to develop improved quality assurance and continuing professional education programs.

Finally, three programs were funded which are designed to train health professionals in new and improved skills in certain new fields.

Specialized Services

The regionalization of specialized services will be assisted by grants in several of the categorical areas. Regionalization of hypertension screening is being spearheaded by the Georgia Heart Association with the cooperation of a number of community hospitals.

Continuation of funding for a stroke area facility in the southern part of the state was granted. Three hospitals were continued as cardiovascular area facilities and a program for evaluation and counseling for children at high risk of atherosclerosis was funded.

Ten hospitals were funded as cancer area facilities and the medical schools both received funds to increase their role as regional facilities. These projects are in line with the statewide program of the Georgia Cancer Management Network.

Improved chronic kidney disease programs were funded at both medical schools and two community hospitals, and a special program which will allow rapid consultation services to physicians in acid/base and electrolyte problems was also funded.

Funds for several activities in regionalization of

chronic lung disease activities were granted.

For the first time this year, RMP was authorized by Congress to fund activities in arthritis and Georgia is fortunate to have received $200,000 earmarked to demonstrate improved arthritis services in the state.

Primary Health

Finally, the improvement of primary health services will be assisted by several groups of projects. The regional emergency medical services program in Savannah and Columbus were continued. A developmental grant for a similar regional system in the Albany area was awarded and the Georgia Hospital Association received funds which will allow them to assist hospitals to complete the statewide emergency radio network.

A large statewide program to assist the implementation of a regionalized system for the care of the high risk mother and infant was funded, with special assistance going to three community hospitals and the two medical schools. Two nurse midwifery projects were funded to assist physicians in areas of particular need.

A group of three projects to assist the development of home health care was funded and a school preventive dentistry program was instituted in a low income area of Metro Atlanta.

Finally, assistance was granted to the Poison Control Center at Grady Memorial Hospital to allow them to provide 24-hour consultation services in cases of poisoning throughout the state.

The diversity of projects described serves to demonstrate the broad scope of GRMP activities. The Regional Advisory Group regrets that funds were not available to fund all requests, but feels that a high quality program will result from those funded projects which will significantly assist health professionals as they work to improve medical care in our state.

Research and Development

This new arm of the Medical Association of Georgia is currently involved in three areas of activity: cancer programs, health data systems, and medical care evaluation.

Cancer: The Georgia Department of Human Resources has contracted with MAG Research and Development for the operation of a statewide cancer registry. The Georgia Cancer Registry is a service to hospitals providing training and assistance to cancer registrars as well as the editing and processing of registry data. It begins operation October 1 of this year and is expected to have up to 19 hospitals participating by that date. It is hoped that an increase in appropriation would be granted next year to allow the registry to serve additional hospitals effective July 1, 1975.

Health Data Systems: A hospital discharge abstract system is being developed to assist medical staffs in the performance of JCAH required medical care evaluation studies utilizing each medical staff's own criteria. JCAH required medical record indexes would also be produced. The data system will be field tested this winter and will become fully operational July 1, 1975. This activity is funded through a cooperative health Statistics Systems grant from the National Center for Health Statistics.

Medical Care Evaluation: The Georgia Regional Medical Program has funded MAG Research and Development to assist hospitals in developing their own medical care evaluation programs satisfying JCAH requirements. The project staff will assist physicians and medical record personnel in the performance of complete medical care evaluation studies, including the development of individual hospital criteria, and retrieval and analysis of information. Special emphasis will be placed in assisting small hospitals.

CHARGE FOR DIRECTORY ASSISTANCE NOT APPLIED TO THE HANDICAPPED

Southern Bell is aware that physicians have a special interest in the recent request to the Georgia Public Service Commission to allow a charge for calls to Directory Assistance, and the company would like to fully explain the proposal for you:

"Southern Bell has no desire to penalize those people whose visual, physical, or mental handicaps make it impossible for them to look up their own telephone numbers. In fact, the rate proposal exempts these customers from additional charges for calls to Directory Assistance.

"These charges have been proposed in order to place the cost for such services directly on those who generate the cost through misuse or abuse. Specifically, the charges are aimed at those who simply will not take the time to look up numbers themselves and to those companies who use the service for such things as credit checks. By placing the expense on those who cause it, Southern Bell will better be able to hold down the cost of the average customer's basic telephone bill.

"Under the terms of the proposal made by Southern Bell, the request for increased local rates could be lowered by 60 cents if the Public Service Commission allows the Directory Assistance charge. The company's overall needs in Georgia would be lowered from $81.5 million to $70 million.

"The plans for implementing a charge for Directory Assistance and providing exemptions have not been finalized, and the permission for the charge must still come from the Public Service Commission. However, Southern Bell assures you that those customers whose visual, physical, or mental handicaps would hinder their use of the directory will be exempt from paying for Directory Assistance calls."

editorials
editorials
editorials

The Georgia Delegation Views the AMA Convention

AS YOU WOULD EXPECT there were so many resolutions, reports and issues debated at the June 23-27 meeting in Chicago there is simply no way of reporting all these actions in a brief article. A summary of all the actions is available, however, on request from any member.

The Georgia delegation (four delegates, four alternates and the officers) was very active, starting each day with a caucus at 7 a.m. and finishing with informal reports at the close of each session of the House. Our delegates covered each Reference Committee Hearing presenting the views of our Association to each. In addition, this year we sponsored a candidate for the Board of Trustees, John Heard of DeKalb County, who ran a good race but was unsuccessful.

Two Prime Issues

The two items which received the lion's share of interest at this convention were first, the method of election of Trustees and second, PSRO. The 1973 Clinical Convention stated that there should be open and simultaneous elections of trustees. The House upheld this position and the election of Trustees was subsequently held, necessitating multiple votes. Previously a nominee had to run against a specific person, frequently an incumbent running for re-election, and it was felt that this mechanism would encourage "new blood" to run for the Board. The results justified this view, for there were eleven nominations for six vacancies and not all incumbents were returned to office.

The second major issue was PSRO and this was hotly debated before the convention started and subsequently at the Reference Committee Hearing. There were 25 resolutions and two reports on the subject, most of which called for an AMA position to seek repeal of PSRO; others, however, called for constructive amendments and participation in PSRO. Reference Committee A heard everyone wishing to speak (there were 64 including Georgia), the majority of whom spoke in support of Georgia's position for repeal. Practically all who spoke though advocated a clear stand, either for or against participation in PSRO.

The Reference Committee subsequently drew up its reports and stated that the Committee believed it unwise to commit the AMA to an inflexible course of seeking repeal. A substitute resolution was offered which made four specific points:

1. That the AMA seek constructive amendments to the PSRO Law particularly directed at the areas of confidentiality, malpractice, development of norms, quality of care and authority of HEW.
2. That the AMA continue to work for legislation allowing peer review in accordance with the profession's philosophy and the best interest of the patient.
3. That state associations electing noncompliance be allowed to follow

such a course, but be urged to develop effective non-PSRO review programs.

4. That if ongoing evaluation of the PSRO program reveals adverse effects on the quality of patient care or conflict with the AMA policy, the Board be instructed to use all legal and legislative means to rectify these shortcomings.

This report of the committee was printed and all delegates had an opportunity to evaluate it prior to its presentation to the House of Delegates. Showing a remarkable degree of willingness to limit further debate, the House overwhelmingly sustained a "call for an immediate vote" on the issue and the Reference Committee Report was adopted by a vote of 185 to 57!

As you are aware the MAG House of Delegates at its May meeting voted overwhelmingly to seek repeal of PSRO. Because of the position adopted by the AMA, the MAG Council will consider the issue once again and is soliciting the views of the individual MAG delegates to guide them.

Many other issues were debated and voted upon at the Annual Meeting. Vice President Ford spoke to the House and stressed the right to privacy. This was subsequently supported by the House as it adopted several Resolutions on Confidentiality of medical records. Approval was given the concept of a national plan for providing health care for migrant workers. A strong stand was taken supporting Peer Review for VA and Public Health Hospitals. The Judicial Council was directed to establish policy with regard to listing physicians and hospitals in "Consumer Guides," and the House approved with minor changes the updated manual on Physican-Hospital Relations. This report is available to members on request.

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What's New in Urology

LABORATORY STUDIES SUGGEST that ribonucleic acid (RNA) tumor viruses may be responsible for the development of tumors of the renal pelvis, ureter and bladder. Urologic cancer research has produced the most exciting recent contributions to our understanding of tumors of the genito-urinary system. Clinical application of the new data includes a better understanding of tumor immunology. The data also provides a clearer understanding of the effects of irradiation on the malignant tumor of the kidney and prostate as well as a new appreciation of the effects of chemotherapy on Wilm's tumors, neuroblastomas and testicular tumors. Ongoing national cooperative studies provide much information regarding various modalities of treatment of these tumors. The combined effect of these exhaustive studies should ultimately result in more effective treatment techniques of tumors. The effects of supervoltage irradiation and cryosurgical therapy of prostatic cancer are already being seen.

Gains in Pediatric Urology

Pediatric urology gained special prominence in reconstructive surgery of the urinary tract. Expansion of the numbers of successful renal transplantations, and the introduction of diagnostic procedures such as ultrasonography were accompanied by new knowledge of stone disease and treatment of urinary tract infections. Urethral valves, a congenital male anomaly conventionally treated by cystoscopic destruction may now be treated by a

closed-electrocautery technique employing a unique urethral hook. Innovative, reconstructive techniques were redesigned to permit repair of the damaged ureter which would otherwise require urinary diversion. Older, multiple procedures for the repair of hypospadias have been replaced on one-stage techniques that provide simultaneous correction of chordee and hypospadias.

Kidney stone research has shown that oxalate transport between the lumen of the small intestine and the blood stream is the primary factor in urinary calculus formation in man. A clinical aspect of this laboratory observation is the development of calcium oxalate stones in intestinal bypass operations for obesity control and in intestinal atresia in infants' procedures which require extensive bowel resection that promote oxalate transport abnormalities. Perhaps these data may lead to medical control of one of man's most ubiquitous maladies.

Of the newer urologic diagnostic tools, ultrasonography is an effective method to differentiate solid from cystic renal masses. Ultrasonic methods are also employed to dissolve bladder and ureteral stones. Direct and indirect radio-nuclide cystographic techniques are useful in diagnosing ureterovesical reflux and in determing the effectiveness of therapy with a minimum of irradiation exposure.

Evaluation of various drugs in the treatment of prostatic cancer has led to the development of a new non-steroid-nonhormonal substance which acts on the prostate like an estrogen without changing plasma testosterone levels. Libido and potentia are unaffected.

The search for the elusive cause of undescended testis in man has resulted in the discovery of a substance produced by the fetal testis which, when absent, causes cryptorchidism or malignant teratoma.

Renal Transplantation

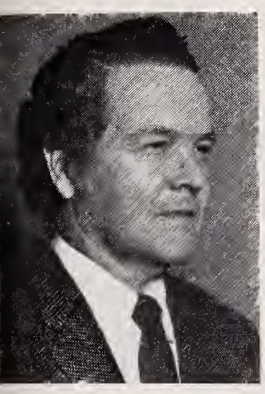
In renal transplantation much has been learned about ureteral urodynamics and ureteral rejection. It has also been observed that changes in renal lymph during rejection is the effect of immuno-suppressants. The kidney acts immunologically like a lymph node. Various drugs such as digitalis and certain antibiotics have been shown to be absorbed by the mammalian urinary bladder. A landmark has been achieved in the treatment of urinary tract infections. A new anti-bacterial agent combines the synergistic action of trimethoprim and sulfamethoxazole, two agents which interfere at different points in a bacterial replication cycle effectively controlling difficult urinary tract infections. Immunological advances provide a better understanding of recurrent urinary tract infection in female patients. The bacterial flora of the female perineum may be a key to understanding the pathogenesis of urinary tract infection, especially as related to bacterial immunology.

The most sophisticated surgical innovation in the past year has been the growth and development of "bench surgery." A serendipitous byproduct of the renal transplantation, dialysis and renal vascular surgical programs, "bench surgery" provides the surgeon an opportunity to inspect, dissect and reconstruct the viable kidney outside the body after a single perfusion. An opportunity is now provided the surgeon to be certain of removal of all renal calculi and in certain selected cases carefully dissect otherwise inoperable renal tumors such as those present in a solitary kidney with little chance of disaster.

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president's letter

Simplifying Complexities



WHAT IS THE MAG? Who speaks for it? What does it stand for? How does it make and implement its policies?

Well, statistically we make up about 80 percent of all the 5,000 M.D.s in the state. We have a House of Delegates which is composed of some 186 members elected from our 66 county societies, and this body has ultimate governing authority for the Association.

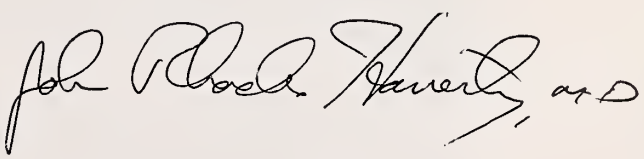
Our Council, acting for the MAG between meetings of the House, is made up of some 50 people, elected in a variety of ways from a variety of constituencies, plus 15 to 20 past presidents. Of this large group, some 27 have voting privileges at any one time.

The Executive Committee handles most of the current business of the organization, meets monthly or more often, and includes 10 individuals, of whom nine have voting rights.

Various kinds of powers and prerogatives accrue to the President, the Secretary, the Speaker of the House, the AMA delegates, committee chairmen, the MAG staff and others, and each can and does speak for organized medicine in Georgia under certain circumstances, and thus may be said to establish "policy" at times.

As can be seen, we are a complex organization. The ways in which we relate to issues and to each other and to other groups sometimes are haphazard and circumstantial. We need more orderly and known and acceptable procedures to function effectively.

Toward this end, next month we plan to have a session of representative medical leaders from throughout the state. We will meet for two and a half days at Unicoi to discuss possible ways of reorganizing the Association to accomplish these goals. Next month on this President's Page, I will present some of the thoughts we will be considering. To be sure, any changes will be presented to the membership for discussion and decision, and nothing will be done precipitously. We hope the eventual outcome will provide a stronger, more cohesive MAG.



John Rhodes Haverty, M.D.
President, Medical Association of Georgia

cancer page
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cancer page

Mastectomy, Yes, But Which One?

PART I: CONSIDERATIONS FOR SURGERY

JOHN P. WILSON, M.D., *Atlanta**

WHETHER ONE CONSIDERS surgery essentially an adjuvant type of therapy or a primary type of therapy, the basic management of breast cancer at present is surgical.

Aside from the many peripheral problems, such as the use of empirical ancillary radiotherapy or chemotherapy, the major controversy resolves around the optimal primary surgical treatment of breast cancer.

Plea for Controlled Studies

No less person than Dr. Bernard Fisher, who is certainly as statistically knowledgeable of breast cancer as anyone, stated at the recent Atlanta Graduate Medical Assembly "Day of Cancer" Meeting in Atlanta that "we do not know how to treat breast cancer." Dr. Fisher pled for more participation in controlled studies by surgeons in order to more quickly evolve answers (his cooperative studies are open to individual private practitioners as well as large groups or institutions). However, a few percentage points difference in therapeutic regimens may percipitate as much controversy as is settled, and joint studies do not necessarily resolve all problems. For any subject which has been the interest of many intelligent and competent physicians for so long a period of time and still presents no universally acceptable answer is unlikely to have a simple, easily attained resolution.

In the meantime, debate over the proper therapy presents a serious burden to the practicing surgeon who must daily make a therapeutic commitment to the patient he is to treat. There are a number of questions which he must weigh.

Is simple mastectomy, as we are able to apply it clinically, truly as effective in controlling breast cancer as radical mastectomy, particularly in the clinical borderline patient?

Do the axillary nodes provide a necessary immune response that is compromised by removal of these nodes?

Is sequential excision of the axillary nodes after simple mastectomy when the nodes do become clinically apparent, as effective in controlling breast cancer as the concomitant axillary dissection or does it occasionally lead to an irretrievable loss?

Is partial mastectomy an effective enough method of treating small cancers of the breast to justify its recommendation, and are the cosmetic differences in such surgery significant enough to warrant its use?

Is the eventual state of the disease whether localized or generalized essentially determined at the time of initial therapy and, therefore, not affected by radical mastectomy?

Has the traditional idea of breast cancer progression by contiguity which has

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been the basis for radical procedures and super-radical procedures been superseded by the concept of breast cancer as a generalized disease?

These are theoretical questions which, at the present time, simply have not been answered.

Factors and Considerations

There are other specific factors which play a part in making a decision as to the nature of the operation to be carried out.

The first consideration is the control of the tumor by the therapeutic modality used. The most desirable control of the tumor would obviously be complete eradication. Unfortunately, this frequently cannot be determined directly, and we must use secondary evidence such as the occurrence of metastatic disease or local recurrence at a later date as a criterion for making this determination retrospectively. These statistics can be collated generally, but there is simply too much individual variation to apply this to an individual case where the differences in results with different therapeutic modalities of five-year survival are very small percentages.

From the patient's standpoint, control of the tumor without eradication is effective therapy, as long as the tumor can be completely controlled. We know that tumors are frequently controlled for long periods of time primarily by the host-tumor relationship and to a lesser extent by therapeutic measures such as hormone therapy, chemotherapy, radiation therapy, etc. Control, therefore, must be interpreted in terms of a given patient for a projected period of time in a specific clinical setting. Control in the 70-year-old female with a medical life expectancy of about two years has a completely different connotation from that of a healthy 35-year-old woman.

In addition to tumor control, however, there are other factors which weigh heavily in determining therapy, particularly when only small or questionable differences in benefit from therapy can be demonstrated. A swollen arm may be of moderate to major importance. Minimal swelling may be of no significance to the patient in terms of activity, but moderate swelling can be inconvenient, and marked swelling can be disabling. This is a serious complication related to therapy from the patient's point of view. Its incidence differs somewhat in various surgeons' experience.

Upper extremity dysfunction other than edema is seldom a serious problem. It is a moderate factor in some persons where there is a requirement for great physical activity and in those patients in whom the surgical therapy has been on the dominant side of the body. Loss of function other than swelling rarely plays a significant role in the quality of survival after successful treatment.

The cosmetic effect is overall more important, particularly to the younger person and is determined not only by the removal of the breast, but whether the pectoral muscles are removed. Radiation therapy may produce some cosmetic problem. The importance of the cosmetic factor quite obviously depends on the individual patient and obviously of more concern to the younger than the older one.

All of these factors play a role in the evaluation and selection of various surgical treatment modalities. ■

(PART II: Types of Mastectomy and Their Indications next month.)

heart page
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heart page

CPK and LDH Isoenzymes in the Diagnosis of Myocardial Infarctions

JAMES E. PHILLIPS, M.D., *Macon**

THE EARLY DIAGNOSIS of myocardial damage has been facilitated over the past 20 years by the determination of various enzymes in the serum of patients who have sustained myocardial damage. This has included the determination of the total level of creatine phosphokinase (CPK), lactic dehydrogenase (LDH), glutamic pyruvic transaminase (SGPT), and others. In more recent years, the specificity of these analyses has been improved by the availability of isoenzyme analysis of CPK and LDH, both of which have recognizable patterns in the presence of myocardial infarct. These patterns are observed in the laboratory after electrophoresis of the serum of patients with elevated total levels of CPK and LDH. Usually, an interpretive report is issued.

Causes of Elevated Enzymes

Often, the elevation of these enzymes, plus the clinical findings, are sufficient to make the diagnosis in cases of suspected infarction. However, other causes of elevated enzymes can occur and, in these cases, isoenzymes are especially useful. CPK is found primarily in muscle and nervous tissue and is absent from other organs, or is present in only minute amounts. Because CPK is confined primarily to muscle and nervous tissue, serum elevations might be expected to reflect damage to a few tissues only and, thus, be a more specific diagnostic aid than LDH and the other more widely distributed enzymes. This is true, but only within limits. It has the advantage of not being elevated in primary hepatic disease or in hepatic congestion due to heart failure. There is also no significant elevation in pulmonary embolism or infarction, and hemolytic disorders and malignancies do not usually result in elevations as they may with other enzymes. However, other causes of elevated total CPKs may be present, which causes a diagnostic problem, especially in the patient with a possible heart attack. Total CPK is elevated after prolonged strenuous exercise, intramuscular injections and muscle contusions, in post-op and post-cardioversion status, post-tetany and grand-mal seizures, and in 60 to 80 percent of hypothyroid patients. Patients with muscular dystrophy will also have elevated CPK and this may be a useful determination in this disease.

Several molecular forms or isoenzymes of CPK are distinguished electrophoretically and are useful clinically in diagnosing myocardial infarctions and in diagnosing other causes of enzyme elevation, as mentioned above. Three have been identified and are designated according to their origin and subunits. CPK is a dimer, having two subunits, M and B, the combinations of which determine the isoenzyme. Skeletal muscle and heart contain CPK III (MM), heart contains CPK II (MB), and brain contains CPK I (BB).

Damage to heart muscle in myocardial infarction causes several enzymes to

* Associate Pathologist for Medical Center of Central Georgia, 777 Hemlock St., P.O. Box 6000, Macon, Ga. 31208. Prepared at the request of the committee of Physician Education of the Georgia Heart Association.

rise, including CPK, SGOT, SGPT, LDH, and others. CPK is the earliest to rise and the first to return to normal. It is elevated in six to eight hours post-infarction, reaches a peak at about 24 to 48 hours, and returns to normal in three to five days. The height is proportional to the extent of infarct, but the total CPK must be determined at the peak to make this correlation. Also, the heart fraction is only a portion of the total CPK liberated from injured heart muscle and is the most labile. It is usually undetectable 48 hours post-infarct, even though the total CPK may remain elevated three to five days. A continued elevation of the CPK II fraction, or a later increase, indicates extention or reinfarction. Because of the short duration of the elevation, serial CPK determination may be useful, especially if they are begun early in the course. The presence of the heart fraction is thought to be virtually diagnostic of myocardial infarction, though its absence does not rule it out.

Helpful LDH Isoenzyme Pattern

Although the CPK heart fraction is the most specific isoenzyme for the diagnosis of myocardial infarction, the LDH isoenzyme pattern is helpful and can provide additional information related to the patient's clinical status. It becomes elevated later and remains elevated longer. Five isoenzymes are seen with electrophoresis of LDH. The molecule is a tetramer, with two basic subunits, A and B. The international nomenclature now adopted designates the LDH 1 and 2 fractions as those found in heart, migrating to the anode. LDH 1 and 2 are found in the myocardium as well as within erythrocytes. LDH 3 is found primarily in the brain and kidney; LDH 4 in liver, skeletal muscle, brain, and kidney; and LDH 5 in liver and skeletal muscle. The infarct pattern usually shows an elevation of LDH 1 and 2, with LDH 1 greater than LDH 2. This peak appears at approximately three to four days and returns to normal within 11 to 12 days.

The combined analysis of CPK and LDH isoenzymes is most useful for several reasons. (1) The CPK heart fraction elevation is of very short duration and its presence may be missed if the timing is late. (2) Some LDH patterns, such as hemolysis and renal cortical necrosis, may resemble the heart pattern and may be difficult or impossible to distinguish. (3) CPK heart fraction may be elevated in a few other illnesses, such as progressive muscular dystrophy, dermatomyositis, polymyositis, and myoglobinuria.

In summary, there are three CPK isoenzymes detectable by electrophoresis. One is primarily of heart origin and is useful in diagnosis of myocardial infarction. It becomes elevated at six to eight hours post-infarct, occasionally earlier, and returns to normal within 24 to 48 hours. Five isoenzymes of LDH are detectable and a specific pattern is associated with myocardial infarction. The combination of both, when serial determinations are made in patients with suspected heart attacks, is a useful adjunct in this diagnosis.

legal page
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The Georgia Securities Act of 1973

LAWRENCE M. GOLD, *Atlanta**

On April 1, 1974, a new state securities law took effect in Georgia.† Designed to provide additional protection for investors and to prohibit certain unscrupulous practices which have plagued the securities industry in our state, the Georgia Act has virtually rewritten the rules for selling securities in Georgia. Among its more significant changes, the Georgia Act requires more disclosure from companies which sell their securities; narrows the exemptions from the registration requirements of the new law; stiffens the registration requirements of brokers and dealers; creates new reporting requirements both for issuers of securities and for the brokers and dealers who sell them; and strengthens personal liability for violations of the new law.

From time to time you may consider investing in securities that are registered under the Georgia Act or which are claimed to be exempt from the registration provisions of the Georgia Act. Moreover, you may be asked to serve as an officer, director, partner or other controlling person in a company which plans to sell securities in Georgia. Consequently, you should be aware that there is now a much more stringent law in Georgia governing the sale of securities. Also, keep in mind that "securities" can include not only stocks and bonds, but also limited partnership interests, certain promissory notes and other types of investment interests.

Significant Provisions

It is not possible to summarize all of the major changes effected by the Georgia Act in the limited space of this article; however the following is a brief outline of several of its more significant provisions.

Additional Disclosure by Issuers. Companies which register securities for sale in Georgia and which do not register these offerings under Federal securities laws, or do not make such an offering under certain specific exemptions promulgated under the Federal Act, are now required to provide each investor with a prospectus. This prospectus must contain detailed information about the business, management, and use of proceeds of the issuer, and, of special significance to new or unseasoned companies, must also disclose the minimum amount the issuer believes it must receive in order to engage in business. Additionally, an issuer registering securities for sale in Georgia must include certified financial statements in its prospectus. If the offering constitutes a "small issue registration" under the Georgia Act, which essentially means an offering involving sales to not more than 25 purchasers, unaudited financial statements may be used, and the disclosure requirements are not as extensive as with full registrations.

Escrows and Rescission. In addition to new disclosure requirements, issuers which register securities for sale in Georgia are subject to certain other restrictions designed to protect investors. Under the old Georgia securities law, officers, directors, and promoters of issuers were required to place their holdings of the

* Prepared at the request of The Medical Association of Georgia. Mr. Gold is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, Eleventh Floor, C&S National Bank Building, Atlanta, Ga. 30303.

† Originally enacted in 1973 by the General Assembly and amended in 1974, this new law is known as the "Georgia Securities Act of 1973" and will be referred to in this Article as the "Georgia Act."

issuer's securities in escrow if they purchased their shares at prices less than the public offering price. Under the Georgia Act when the issuer is new or unseasoned and has no firm commitment underwriting agreement for the offering, that is, an agreement with an underwriter that no securities will be sold unless all of the securities are sold, insiders may also be required to place securities held by them and purchased at prices less than the public offering price in escrow for one year after the termination of the offering. Furthermore, in registered offerings of this type, the issuer will be required to place the proceeds of the offering in escrow until it has received the minimum amount required to conduct its business, which, as previously noted, must be disclosed in the prospectus.

In order to prohibit high-pressure sales tactics, an investor has the right to cancel any subscription in a registered offering within 72 hours after signing his subscription. This right of rescission must be noted in a legend placed at the beginning of any prospectus used in the offering.

Exempt Transactions. Provisions regarding transactions exempt from registration under the Georgia Act also differ in several significant respects from those under the old law. The most important change involves the limited offering. The familiar 6(j) exemption for *offerings* to not more than 25 persons has been eliminated. Instead, an exemption is now available for *sales* to not more than 15 persons in any 12-month period. Although no petition or affidavit need be filed with the Securities Commission as was the case under former section 6(j), there are conditions to the availability of this exemption. For example, no general advertising can be used in connection with sales; the securities must bear legends reflecting the exemption under which they were issued and indicating the restrictions against resale which apply to them; and each purchaser must evidence his investment intent in writing. These latter requirements are necessary since securities acquired in a transaction exempt under this provision of the Georgia Act may not be resold in the absence of registration or an available exemption under the Georgia Act.

Liability of Controlling Persons. The personal liability of controlling persons, such as officers and directors of corporations, has been strengthened in the Georgia Act. Under the new provision any controlling person who participates "in any material way" in any sale of securities in violation of the Georgia Act is jointly and severally liable for the violation unless such person can establish that he did not know, and using reasonable care could not have known, the facts on which liability is based. This so-called "due diligence" defense, which was added in the Georgia Act, is an extremely difficult matter to establish.

Prohibited Activities

Certain practices have been expressly prohibited by the Georgia Act. For example, no representation can be made in connection with the sale of any securities registered under the Georgia Act that securities of the same class will be sold by the issuer in the future at a price higher than the offering price or that a market for the securities will develop. Also, promissory notes given to purchase securities registered under the Act must bear legends reflecting the fact that they were given for this purpose, and the Georgia Act prohibits any holder of such a note from being a "holder in due course," which essentially means that any holder of such a note is subject to any defenses that the maker of the note may have against the issuer.

Keep in mind that the provisions of the Georgia Act do not affect the registration requirements, exemptions or liabilities contained in Federal securities laws and that in addition to the Georgia Act, these laws may also apply to any offering of securities.

If you have become involved, either as a purchaser or as a controlling person, with an offering of securities or are considering such involvement, you should consult your attorney for more information about the new law and its possible effects upon your personal situation. ■

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Hewes, Thomas F. Muscogee—Active—FP	Medical Center Columbus, Ga. 31902
Kerley, Clifford M. DeKalb—Active—R	5247 Forest Springs Dr. Dunwoody, Ga. 30338
Kocacitak, Sahin S. Walker—Catoosa—Dade—Active—SU	Tri-County Hospital Ft. Oglethorpe, Ga. 30742
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Wasden, Howell A. Muscogee—Active—FP	Medical Center Columbus, Ga. 31902
Waters, Donald B. Muscogee—Active—FP	Medical Center Columbus, Ga. 31902

SOCIETIES

Bibb County Medical Society members celebrated the summer with a gala South Sea Island picnic for their August meeting, a social event that welcomed new members and their wives. Ninety-nine Macon physicians have been appointed as clinical associates on the founding clinical faculty of the Mercer University School of Medicine. The volunteers will give their time toward planning and teaching activities. The following physicians will be working to recommend an organization for faculty business: James Achord, Waddell Barnes, Robert Donner, Hugh Gibson, Milford Hatcher, Milton Johnson, Jr., Earl Lewis and Oscar Spivey. Beverly W. Forester is serving as chairman of the Greater Macon Chamber of Commerce Task Force to develop the medical school.

Members of the **DeKalb County Medical Society** were honored by the county school system at a dinner meeting July 15 for their services in giving physical examinations and coordinating the school athletic program. Presented with plaques were Drs. Duane Blair, Robert F. Eaves, Harry Foster, Willis T. McCurdy, Mel T. Moore and John M. Schreeder.

August 20 was family night for the **Medical Association of Atlanta,** celebrated with an old fashioned barbeque and appearances by Democratic and Republican candidates for Governor and Lieutenant Governor who had survived the primary. The scheduled September program was "Current Concepts in Cancer Chemotherapy" led by Dr. Benjamin Kahn of Philadelphia.

PERSONALS

Fourth District

John B. Griffin has been promoted to associate professor of psychiatry at Emory University.

Fifth District

Emory professor of pediatrics **Andre J. Nahmias** has been awarded a March of Dimes bio-medical research grant of $39,129 for one year and will study infection of newborn infants with herpes simplex virus (HSV).

Robert C. Schlant of Emory has received from the Georgia Heart Association continuing support as holder

of the Chair of Cardiovascular Research at that medical school.

Northside Hospital Director of Pathology **L. David Stacy** was the featured speaker at a recent meeting of the National Foundation for Sudden Infant Death, Metro Atlanta Chapter.

Thomas E. Whitesides, Jr., professor of surgery (orthopedics) has been appointed chief of the Division of Orthopedic Surgery of the Department of Surgery for Emory University School of Medicine and Emory University Clinic.

Sixth District

Dublin internist **W. Patrick Roche, Jr.**, has been appointed to the Laurens County Hospital Authority to fill the unexpired term of another board member who had resigned.

W. Mark Watkins, Dublin physician, is moving to Columbia, S.C. to serve on the staff of the Student Health Center of the University of South Carolina. Dr. Watkins has served as chief of staff of the Laurens Memorial Hospital and president of the county medical society.

Seventh District

The life of **William Ralph Bottoms** of Cummings was the subject of a regular column on Forsyth County history in *The Forsyth County News* in May.

Eighth District

Blackshears's **William A. Hendry** has retired from practice after 35 years of service in that Southeast Georgia community. Dr. Hendry is a past president of the Ware County Medical Society and Chief of Staff of Pierce County Hospital.

Avery Wade Strickland of Brunswick has been named a Diplomate in internal medicine and cardiovascular diseases.

Ninth District

The Cartersville Rotary Club had as its guest speaker in July **Oscar M. (Jim) Wilbur,** pathologist and director of laboratories at Sam Howell Memorial Hospital.

Tenth District

Charles Henry Dickens, 84, of Madison, recently was honored in Morgan County by members of the Madison Lions Club for his 52 years as a practicing physician there. A feature story in the local paper about Dr. Dickens recalled that when he began practice in 1914 an office visit was $1, a house call $2 and 50 cents per mile when patients lived several miles out of town. Dr. Dickens estimates that he has delivered 6,000 babies in his long career.

James B. Hudson of the Medical College of Georgia in Augusta has received continuing support as the holder of the Chair of Cardiovascular Research from the Georgia Heart Association.

DEATHS

Earl W. Hathcock

Earl W. Hathcock, Jr., 40, of Atlanta died July 31.

Dr. Hathcock was graduated from the Medical College of Georgia, served his internship at Crawford W. Long and his residency at Grady Memorial Hospital. Dr. Hathcock served as a lieutentant colonel in the U.S. Army Medical Corps.

The obstetrician-gynecologist had been active in the development of Northside Hospital and served as chief of staff in 1971.

Survivors include his widow, Mrs. Martha Hayes Hathcock; daughters, Katherine Ruth, Barbara Jane and Kelly Lambert Hathcock of Atlanta; parents, Mr. and Mrs. Earl W. Hathcock, Sr., of Ellenwood; sister, Mrs. Will Gosnold of Carrollton, and brothers, John M. Hathcock of Statesboro, Phillip W. Hathcock and Stanley L. Hathcock of Atlanta.

Edwin C. Jungck

Augusta physician Edwin C. Jungck died July 17 at his home. The Portland, Oregon native received his M.D. and Ph.D. degrees from the University of Oregon Medical School. He was a former teacher and had served in the U.S. Air Force two years.

Dr. Jungck began practice in Augusta 20 years ago and served as an assistant professor in clinical endocrinology at the Medical College of Georgia.

Survivors include his daughter, Martha Jungck.

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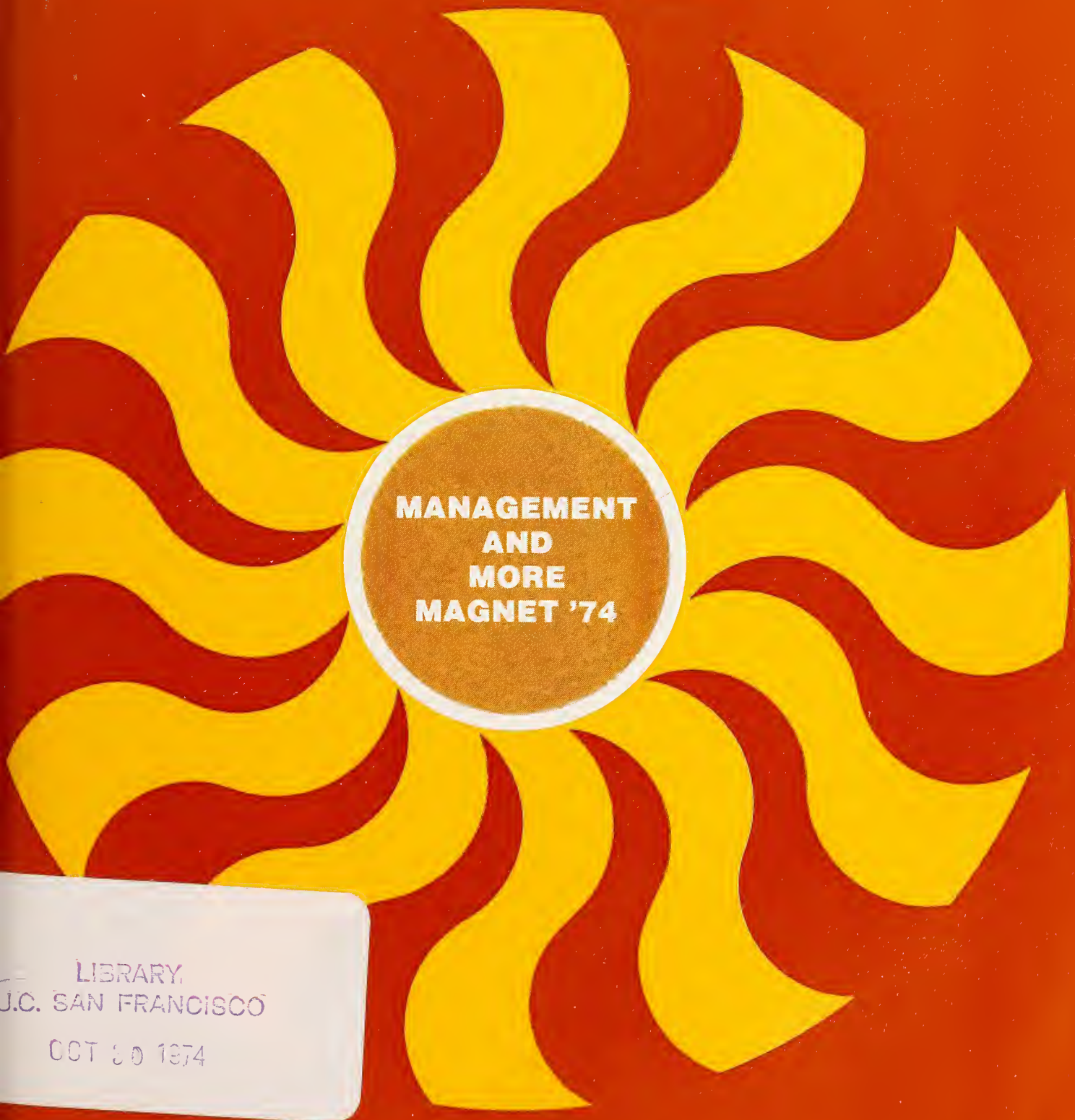
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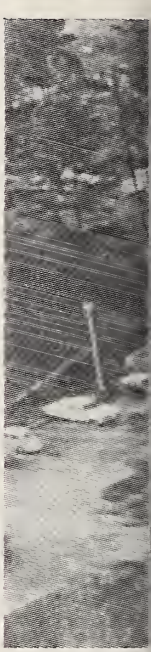
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Good management techniques are essential to today's medical practice. MAG is sponsoring its annual MAGNET Conference in November which promises expert advice on how to set the wheels in motion for a well-run practice. See the Editorial Page for details. Design by Bob Hamill, Atlanta.

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Causes of death and methods of prevention are discussed.

The Prevention of Mortality Following Intestinal Bypass for Obesity

CHARLES E. WILLS, JR., M.D., *Washington**

THE INTESTINAL BYPASS for obesity has been described as a dangerous, radical procedure. Many investigators have advised the bypass only in the morbidly obese because of the dangers, side effects and unknown possible long term ill effects.[1]

All authors who have reported substantial series of cases have reported mortalities. The overall percentage of mortalities have varied from as low as 1 per cent[2] to a high of 16 per cent.[3] This obviously varies with the length of time the cases are followed, the selection of cases and the type of bypass performed. The accepted overall mortality rate is approximately 3 per cent.

This article will attempt to describe 26 mortalities that have occurred in a series of 438 intestinal bypasses. An attempt will be made to categorize and analyze these mortalities as to causes and how they might have been prevented.

Materials and Methods

Four hundred thirty-eight intestinal bypass procedures were performed between November 1963 and February 1974. Table 1 demonstrates the number and type of bypass performed. The ages varied from age 13 to 63. The weight varied from 142 to 580 pounds and averaged 248 pounds. Twenty-six of these cases are dead. Autopsies were performed on 16 cases.

Table 2 lists the causes of death by category. Thirteen deaths were due to cardiovascular causes, three due to fulminating pancreatitis, three due to infections, three due to cirrhosis of the liver, two due to automobile accidents, one due to suicide and one due to Cushing's disease.

RESULT I

Deaths Obviously Unrelated to the Bypass Surgery and Considered Unpreventable as Such

Case 1: Thirty-three-year-old white female committed suicide seven months postoperatively. She

TABLE 1
TYPES OF BYPASS

	Inches of Jejunum	Inches of Ileum	Number of Cases
1. Jejunocolostomy	20	0	3
2. Jejuno-ileostomy— end to side	15	10	12
	15	8	2
	14	4	394
3. Jejuno-ileostomy— end to end	10	12	25
	14	4	2

TABLE 2
CAUSES OF DEATH CATEGORIZED

1. Cardiovascular	13
2. Fulminating pancreatitis	3
3. Infectious	3
4. Cirrhosis of the liver	3
5. Automobile accident	2
6. Suicide	1
7. Cushing's disease	1

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had been hospitalized at the state mental hospital twice before bypass surgery with a diagnosis of schizophrenia. She shot herself in the chest with a shotgun while on leave of absence from the state mental institution.

Case 2: Forty-nine-year-old white male was killed when he was run over by an automobile while flagging traffic for the state highway department five months postoperatively.

Case 3: Fifty-six-year-old white female died as a result of injuries received in an automobile accident 26 months postoperatively.

Case 4: Forty-five-year-old white male died of cardiopulmonary failure after an episode of influenza 26 months postoperatively.[4]

An autopsy was not obtained on any of these cases.

RESULT II

Deaths Possibly Indirectly Related to the Bypass but Considered Unpreventable

Case 5: Fifty-five-year-old white male weighing 335 pounds died five days postoperatively due to hemorrhaging esophageal varices. Cirrhosis of the liver was unexpectedly found at the bypass surgery. This was confirmed by autopsy.

Case 6: Thirty-nine-year-old white male weighing 327 pounds died 24 months after bypass surgery due to hepatic failure. Cirrhosis of the liver was found unexpectedly at bypass surgery. He was a heavy alcoholic both before and after his surgery. An autopsy was obtained.

Case 7: Sixty-year-old black female weighing 376 pounds died two months postoperatively in another hospital with a diagnosis of cerebral hemorrhage. Preoperatively she had benign hypertension. An autopsy was not performed.[4]

Case 8: Forty-year-old black female weighing 297 pounds died 18 hours postoperatively due to massive coronary occlusion. She also had diabetes mellitus. An autopsy was not obtained. The diagnosis was made by clinical observation, serial electrocardiograms and enzyme studies.

Case 9: Thirty-five-year-old white male weighing 297 pounds died 75 days after the bypass due to massive coronary occlusion. An autopsy was not obtained. The diagnosis was made by clinical observation, serial electrocardiograms and enzyme studies.

Case 10: Forty-three-year-old white male weighing 283 pounds suffered a cerebral hemorrhage 16 hours after bypass surgery. He was kept alive for 100 days by massive supportive treatment in a veteran's hospital. Autopsy was obtained. He had a 20-year history of obesity, heavy smoking, heavy alcoholism and diabetes mellitus. The stage was probably set preoperatively for this complication.

RESULT III

Deaths Indirectly Related to the Bypass Surgery and Possibly Preventable

Cases 11-16: Six cases died due to massive pulmonary embolus. One of these was nine days after surgical revision of her bypass which was five months after her original surgery. The other five were 8, 13, 24, 45 and 90 days postoperatively. Their ages were 40, 30, 61, 55, 35 and 53. They weighed 394, 408, 252, 348, 245 and 289 pounds. The diagnosis was proven by autopsy in five cases and the other had a classic clinical picture of massive pulmonary embolus. After studying the above statistics it appeared that the danger of death due to pulmonary embolus is mainly in heavier and older patients. All of the deaths occurred in the first 194 cases. As a result of this analysis the remaining 244 cases were treated differently and no deaths from pulmonary embolus have occurred. In these cases Teflon Inferior Vena Cava Partial Occlusion clips have been applied to all cases over 300 pounds, all cases over 40 years of age and all cases with a history of venous disease of the lower extremities (thrombophlebitis, varicose veins, etc.). See Tables 3 and 4. One hundred two of these 251 cases have qualified under these qualifications for placement of the vena cava clip.

RESULTS IV

Deaths Directly Related That May Be Prevented

Case 17: Fifty-two-year-old white female weighing 256 pounds died 25 months postoperatively due to cirrhosis of the liver with hepatic failure. At the time of bypass the liver appeared normal. A biopsy was not taken. Postoperatively she had a prolonged period of severe nausea. An autopsy was performed.

Case 18: Thirty-nine-year-old white female weighing 232 pounds died seven months after bypass surgery due to cirrhosis of the liver and hepatic failure. A liver biopsy at the time of bypass surgery demonstrated fatty metamorphosis. Postoperatively she had severe nausea. She did not return for postoperative checkup and refused treatment against advice five months postoperatively. She expressed a desire to die. The diagnosis was confirmed by autopsy.

Case 19: Forty-five-year-old white male weighing 268 pounds had a history of coronary occlusion three years before bypass surgery. He had cardiac standstill on the operating table. He was resuscitated with cardiac massage but suffered irreparable brain damage and died from a pulmonary embolus twelve days later. An autopsy was obtained.

Case 20: Twenty-year-old white male weighing 325 pounds was noted to have a tachycardia eight hours postoperatively. Eighteen hours postoperatively he was in hemorrhagic shock. He was given blood transfusions and the abdomen was reopened demostrating acute hemorrhagic pancreatitis and multiple bleeding areas in the stomach. Forty-eight hours postoperatively he was dead. An autopsy was obtained demonstrating fulminating hemorrhagic pancreatitis and massive coronary occlusion.

Case 21: Forty-four-year-old white female weighing 253 pounds died three years postoperatively due to cardiac standstill in another hospital while receiving potassium for potassium deficiency. Previous to this she had generally had a difficult course with malnutrition and chronic potassium deficiency being the dominating features. An autopsy demonstrated an adenoma of the adrenal gland (Cushing's disease).[5]

Case 22: Forty-year-old white female weighing 315 pounds. This patient had her bypass uneventfully and was discharged from the hospital seven days postoperatively. She had been home only a few hours when she developed acute right upper quadrant abdominal pain that later was demonstrated to be acute cholecystitis. The gallbladder was examined at surgery seven days before and appeared to be normal. The decision was made to treat this conservatively. A surgeon's "nightmare" occurred over the next 10 days. All treatments either failed or seemed to make the patient worse. Acute pancreatitis, acute cholangitis, acute thrombocytopenic purpura, lower nephron necrosis and hemorrhaging esophageal varices occurred before the patient expired 17 days postoperatively. Autopsy was obtained demonstrating the above mentioned diagnosis.

Cases 23-24: These two cases died due to gram negative septicemia. Thirty-year-old white male weighing 580 pounds died suddenly four days postoperatively. He was not ill clinically. An autopsy demonstrated multiple abscesses of the lungs, kidneys and liver along with a small abscess near the appendix stump.

Thirty-three-year-old white female weighing 243 pounds died 26 days postoperatively. Probable mental retardation and emotional immaturity were noted preoperatively. She had an uneventful postoperative course and was discharged from the hospital six days postoperatively. Eleven days later she suddenly became acutely ill and was treated at another hospital. The clinical picture was one of shock with hypovolemia, electrolyte imbalance, renal failure, severe acidosis and gram negative sepsis. In spite of therapy she died eight days later. An autopsy was refused. The attending physician thought she probably developed a leak at the anastomosis site that was followed by gram negative sepsis.[6]

TABLE 3
CRITERION FOR VENA CAVA CLIP PLACEMENT

1. Over age 40
2. Over 300 pounds in weight
3. Venous disease of the lower extremity

TABLE 4
RESULTS OF PROPHYLACTIC VENA CAVA CLIP PLACEMENT

	Case	Deaths
Without vena cava clip placement	194	6
With vena cava clip placement, according to criteria in Table 3	244	0
Number of clips applied	102	

Case 25: Thirty-four-year-old white female weighing 221 pounds died eight months postoperatively due to cardiac standstill while taking intravenous fluids with electrolytes for electrolyte imbalance. Previous to her bypass surgery she had institutional psychiatric care with a diagnosis of schizophrenia. For six months following her bypass she had no problems. At this time she developed calcium and potassium deficiency. She was hospitalized and these problems were corrected. She was sent home with prescriptions for calcium and potassium oral supplements. Two months later she returned to the hospital stating that she had tried to get the prescriptions filled at two drugstores unsuccessfully so she did not take the oral calcium and potassium. She was deficient again. Cardiac standstill and death occurred while taking intravenous fluids and electrolytes. An autopsy was not obtained.

Case 26: Fifty-two-year-old white female weighing 218 pounds. Preoperatively she gave a history of cystitis several times treated medically. Her blood urea nitrogen was 21 mgm./100 ml. This patient had a stormy postoperative course with symptoms suggestive of renal failure, pancreatitis, hemorrhaging stress ulcer and pneumonia. She survived this and was discharged three weeks postoperatively. She did well for five weeks then suddenly became critically ill, went to another hospital and expired 36 hours later. An autopsy demonstrated severe bilateral pyelonephritis, nephrocalcinosis and chronic pancreatitis.[7]

Comments

1. Deaths in Result 1 are considered unrelated to the bypass surgery and as such, unpreventable.

2. Death due to massive pulmonary embolus has been prevented by the use of a Teflon Inferior Vena

Cava Partial Occlusion clip in selective cases in this series. See Tables 3 and 4. In an effort to prevent pulmonary embolus, legs were wrapped at surgery, legs were exercised once an hour for 12 hours and ambulation was started on the day of surgery. Admittedly this has been carried out more vigorously in the later cases than in the early cases.

3. Deaths are more common in older age groups. Probably no cases over age 60 should be done. Eliminating all over age 50 would lower the mortality rates, but this group should not be denied the privilege of this surgery because of this statistical advantage. Many patients in this age group are very pleased with bypass results.

4. Mortalities are more frequent in cases with cirrhosis of the liver. Bypass surgery is contraindicated on the symptomatic cirrhotic. The problem is in diagnosing the asymptomatic cases. Liver function studies are usually near normal in these cases. Diagnosis can only be made by liver biopsy. In this series six cases were unexpectedly discovered at surgery. This incidence is not high enough to warrant preoperative liver biopsy in all cases. Good results with no apparent ill effects on the cirrhotic liver have occurred in four cases. One of these has been followed for six years. Eliminating asymptomatic cirrhotics will lower the mortality but these cases should not be denied the benefits of the bypass. Ingestion of alcohol after the bypass is advised against by Dr. Payne.[8] Certainly alcoholic beverages are contraindicated in bypass cases who have cirrhosis.

5. Preoperative psychological testing might appear to eliminate some postoperative problems; however, I have not been able to predict these problems preoperatively. If all cases with emotional problems were eliminated, very few bypasses would be done. Frame[9] and Solow[10] have presented papers describing the many emotional problems related to obese bypass cases.

6. After Case 18, in which cardiac standstill occurred, a cardiac monitor has been used at surgery. No additional cases of cardiac standstill have occurred. A cardiac monitor might discover cardiac arrhythmias that often precede cardiac arrest and thus alert the surgical team to prevent cardiac arrest or to promote more rapid treatment of cardiac arrest.

7. Acute pancreatitis occasionally occurs following any type of surgery. The cause is unknown. The abdomen is routinely explored at bypass surgery. Overzealous palpation of the pancreas might traumatize the pancreas and precipitate pancreatitis.

8. Death in Case 20 due to Cushing's disease might have been prevented had the diagnosis been made. Cushing's disease should be suspected with obesity, hirsutism, muscular wasting and potassium deficiency. In cases with this clinical picture consultation with an endocrinologist should be obtained. The diagnosis of Cushing's disease is far too complicated for most physicians. The incidence of Cushing's disease is so rare (one case in 438 in this series) that it is not practical to have an endocrine consultation in every case preoperatively.

9. Early cholecystectomy might have saved Case 21. The incidence of gallbladder disease at the time of surgery in this series was 11 per cent. Additional cases have had their gallbladder removed previous to bypass surgery and others after their bypass surgery. Salmon[11] reported a total incidence of gallbladder disease of 41 per cent in 120 bypass cases. Baber[12] suggests the possibility of prophylactically removing the gallbladder at the time of bypass even if it does not appear diseased.

10. Postoperative antibiotics prophylactically might have saved Case 22. They have not been given routinely, but since this case they have been given to the larger and poorer risk bypass cases.

11. Early awareness for gram negative sepsis is necessary. Massive treatment must not wait for a definite diagnosis. It must start immediately if it is suspected. Diagnosis and treatment both are more difficult with obese cases than with nonobese cases.

12. Eliminating mentally retarded cases will improve mortality rates and also general success with the bypass.[13] A certain amount of intelligence is required to be able to cope with postoperative complications and side effects.

13. Electrolyte imbalance is common after bypass surgery primarily involving calcium, potassium and magnesium. Patients must be educated to these problems. Oral supplements should be used freely. Severe deficiences should be prevented and should not occur. Severe deficiencies are potentially fatal.

14. Improved methods of preoperative evaluation probably would have contraindicated bypass surgery on Case 25. Apparently severe renal and pancreatic disease were present before bypass surgery. The usual methods of detection such as history and physical examination, routine urine examination and blood urea nitrogen may not always demonstrate severe disease.

15. Symptoms of continued malaise especially with nausea are danger signals. Further clinical and laboratory evaluation is essential. You must not wait for confirmatory laboratory evidence to start treatment. In the milder cases intravenous fluids, electrolytes and vitamins may suffice. In more severe cases 10 days of hyperalimentation have produced dramatic relief of symptoms. If this does not work taking down the bypass must be considered.

Conclusion

1. Teflon Inferior Vena Cava Partial Occlusion clips have eliminated death from pulmonary embolus in 250 consecutives cases when applied to all cases over 300 pounds, all cases over age 40 and all cases with a history of venous disease in the lower extremities.

2. Alcoholic ingestion must stop in all cases where cirrhosis of the liver is found.

3. The heart should be monitored with a cardiac monitor during surgery.

4. Gentle palpation when exploring the abdomen is important especially with some organs such as the pancreas.

5. Endocrine consultation should be obtained in all cases in which obesity, hirsutism, muscular wasting and potassium deficiency are found.

6. Early cholecystectomy should be performed when acute cholecystitis is diagnosed even though it is in the early postoperative period.

7. Prophylactic postoperative antibiotics are indicated in the very large poorer risk bypass cases.

8. Early massive therapy for gram negative sepsis should be started on suspicion. Do not wait for a definite diagnosis.

9. Patients should be educated in regard to the possibilities, symptoms and treatment of electrolyte imbalance.

10. Better methods of preoperative evaluation are needed. The usual clinical and laboratory testing methods may fail to reveal advanced major organ disease.

11. Prevention of complications is especially important because detection and treatment of complications are much more difficult in obese patients. ■

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SOUTHERN MEDICAL ASSOCIATION BRINGS ANNUAL MEETING TO ATLANTA

More than 6,000 physicians and paramedical personnel are expected to gather in Atlanta November 17-20 for the 68th Annual Scientific Meeting of the Southern Medical Association (SMA).

The annual meeting features scientific sessions of 21 medical specialties from allergy to urology. Section work is augmented by general sessions, joint sessions, special symposia, scientific closed circuit television programs featuring surgical procedures and demonstrations live from a local hospital, live teaching demonstrations at the site of the meeting, postgraduate courses, learning center with experts in chosen fields, meetings of conjoint societies, and scientific and technical exhibits.

All facets of medicine will be covered during the Atlanta meeting which is open to all physicians including residents and interns, medical students, nurses, technicians and other paramedical personnel.

More than 200 scientific and technical exhibits will be of major interest to physicians, and addresses by outstanding guest speakers for each of the medical specialties will highlight the conference where physicians and other medical professionals from throughout the South will gather to hear lectures covering all phases of medicine and take part in panel discussions.

Meeting conjointly with SMA will be several distinguished medical groups: Flying Physicians Association, Society for Investigative Dermatology, Southern Gynecological and Obstetrical Society, Radiological Society of North America, American Academy of Pediatrics and American Fertility Socicty.

The scientific program will include postgraduate courses on pediatric urology, fetal monitoring, occupational medicine, surgical techniques in hand surgery, progress in rheumatology, dermatology for non-dermatologists, diabetes, basic clinical electrocardiography, cardiology, management of low back problems, and common disorders of larynx, pharynx and neck.

An important part of the annual meetings, lunch and learn sessions are sponsored by the various specialty sections and feature outstanding moderators and topics of interest for all physicians.

Although concentration is centered on medical and scientific programs, a number of social functions have been planned for SMA members. The annual golf tournament; alumni reunions; special activities for the Woman's Auxiliary, including sightseeing tours and luncheons; and the president's dinner-dance featuring world renowned Patrice Munsel.

Founded in 1906, SMA has grown to more than 22,000 physician members in 16 southern states and the District of Columbia. The exclusive purpose of the Association is to develop and foster scientific medicine.

Practical suggestions are given on the development of rural health systems and the recruitment of physicians.

Road Ahead—Challenges for Cooperative Action

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THE TWO BASIC HEALTH care problems of rural areas are medical manpower and organization of services; the most acute needs are for more primary physicians and for better organization of primary medical practice. Solving either of these would aid in accomplishing solution of the other. Adequate manpower enables the task of organization to go further than it otherwise could, and group organization of practice can make recruitment and retention of physician manpower easier to accomplish. Of the various methods considered for geographical redistribution of medical manpower to rural areas, the one that may hold the greatest promise is recruitment of physicians to organized groups.

Health Care Systems

It is certain that many small communities that once had their "own" physician will never again have one of their own. It has become clear that, for some rural areas, solutions completely different from the traditional "physician in residence" must be sought. In such areas, emphasis may be needed on expanded transportation and communication capabilities, part-time use of physicians and allied health workers, improved biomonitoring technology, use of new physician support occupations, better understanding of individual health practices, and development of emergency care and self-help methods to ensure rural health coverage.

Multiple communities in a logical service area will need to plan together to develop health care systems on an area basis to attract appropriate health manpower working in a group to provide home, clinic, and hospital care. Planning for health services on an area basis makes it necessary to think in terms of time rather than distance. Planning must also recognize divergent needs for services requiring new types of health workers, technology, and emergency care practices.

Basic to the development of rural health systems is the initial planning by rural communities. It must be regional in scope, based on economic service areas. It must involve all segments of the community, provider and consumer alike, with support of planning agencies and government at the county, state, and federal levels. It must be elastic and tailored to the geography and the potential resources of the locality. Hopefully, the plans will always provide a "one-door" service for all economic levels rather than serving the middle class or becoming an indigent clinic serving only the poor.

We must emphasize that there is no one, simplistic solution applicable to all medically deprived rural locales; rather, each area will need to develop its own plan, incorporating those approaches most appropriate to its particular needs. Of prime importance is coordination of planning. There is an urgent need for system development with physician and hospital linkages.

In applying the community systems approach to the delivery of health services, a real problem of concern is seen to be not simply health care or medical organization within the community, but rather community organization for health care in the context of the total community with all its objectives and problems.

Educating community leaders to the potential of rural development, including planning for readily available and accessible health services, can play a significant part in improving the quality of country living. To support such an educational approach, the Council on Rural Health cooperates with the U.S. Department of Agriculture in an effort to encourage direct communication and participation between state medical association rural health committees and their respective state USDA rural development

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committees. The response to the Council's communication with the state USDA rural development committees has been gratifying. Most of the state RD committees are contacting and seeking guidance from the physician chairmen of the rural health committees. They are anxious to involve physicians and others concerned with health care in the RD program.

Other Developments

The increase in activity at state and community levels has also been encouraging. There has been increasing awareness of the need to bring rural communities and health professionals together; among the approaches utilized have been the expansion of medical society placement services, utilization and development of health careers councils, and assistance by medical and allied professional schools and other groups in disseminating information to physicians and other health professionals on practice opportunities and job openings in rural areas.

Several states have sponsored job fairs where physicians were brought together with rural community leaders in an effort to help place medical manpower in areas of need. Feedback from the Illinois State Medical Society for their 1971 Job Fair indicates that 12 communities secured a physician as a result of the meeting.

There has been increased recognition that solutions to rural health care delivery problems require an alliance of medical societies, schools and universities, farm groups, government agencies, and consumer groups. Emphasis is being given to the need for an area health service approach with emphasis on group practice, health education, expanded use of allied health professionals, improved rural emergency medical services, and the need for relationships with medical schools, state and area Rural Development committees, health career councils, and other groups concerned with development of health care programs for the rural population.

This is as it should be. Just as a variety of approaches to increasing availability of care will be needed from one area to another, so success within a given planning area will require the involvement and support of a broad range of local groups and interests.

At the 1974 National Conference on Rural Health, a number of different approaches to increasing the availability of rural health services were examined in Workshop Sessions. Conferees agreed that each health service area will need to develop its own plan for health care services incorporating those approaches most appropriate to its particular needs.

Some approaches emphasized at the Conference included job clinics such as those sponsored in Illinois, Minnesota, and Oklahoma; loan forgiveness programs for medical students as developed by Kentucky and Illinois with special consideration given to selection of students whose background and motivation are conducive to their selection of a rural locale for practice; the National Health Service Corps, which helps to provide health manpower in underserved areas; AMA's Project USA which will provide physicians for short periods of time to relieve the NHSC physicians; and extensive use and development of placement services such as the AMA and state medical association placement services, and the Michigan and Virginia Health Councils.

Emphasis was given to the importance of continuing education for the physicians practicing in rural areas. Medical schools must develop programs which extend into the communities.

Essentially, conferees agreed that real improvement in availability of health services at the community level will be best accomplished by a meaningful partnership between health providers at the local level and the citizens of the area.

Recruitment Strategies

Manpower recruitment depends basically on manpower training. Training is so distinctly the key to recruitment that it is likely to become a key issue.

Administration spokesmen have talked of redirecting federal financial assistance from health-professional schools to the students . . . who, in return,





The Tenth Annual Georgia Rural Health Conference in Macon at the end of August attracted physicians Irving D. Hellenga of Toccoa (L), chairman of the MAG Rural Health Committee, and Joseph A. Wilber of the Department of Human Resources, a speaker on "Hypertension." E. R. Hensley of Waynesboro (R) congratulates a 4-H project winner. Theme of the conference was "Rural Health Medical Services—How, When and Where Available."

would commit themselves to practice where their services are most needed.

The proposed commitment could be regarded as indentured service—and expression that rings unpleasantly in our democracy. Yet a majority of students in a California survey said they would be willing to accept primary-care assignment prior to specialization.

Planned exposure of medical students to rural practice and life-style has been a continuing effort of several medical schools. Fifty family medicine programs now exist in medical schools providing clerkships or preceptorships for family medicine in a community setting. The preceptor, preferably in a group practice, must be carefully selected. Several promising demonstration projects are under way such as the one in Maine which involves arranging clinical field experiences in rural areas under university staff supervision for teams of health students from colleges and universities in Maine and other New England states. Much greater effort and expenditure of resources is needed in this phase of medical education.

Direct medical school involvement with local communities and their problems is another promising development. This move toward a regional concept of rural health care delivery with rural-urban linkages is successful in several small communities. Decentralized medical education is exemplified in exploratory programs such as the Illinois Plan, the Minnesota Physician Associate Plan, SAMA student projects, and Area Health Education Centers linking health service organizations and educational institutions serving students, practitioners, and communities.

Perhaps a central clearinghouse could be established that would gather profiles of each rural-minded trainee and each recruiting area . . . and match those that indicate kindred values and expectations.

All recruitment must be seen as a two-sided consideration. Not only must the student be adequately prepared for rural practice, the rural area must be adequately prepared for the graduated student. A basic preparation that communities must make is to think and plan in terms of two or more doctors, at least, rather than one. As the experience of the National Health Service Corps has forcefully demonstrated, two doctors are easier to keep than either of them would be alone. Two doctors mean a helpful peer relationship. They mean that one of them has the opportunity for continuing education, other activities, and leisure while the other works.

Future trends dictate that the search for rural health manpower must generally be geared to an area-wide health care system. Nowhere can this be done better than in the small towns with which we are most concerned. They can identify their own nurses, active or retired, technicians, teachers who have health skills, or others who can be trained to perform relatively simple, but nonetheless critical, services. A nurse with special training or other specifically trained assistants can relieve the physician of many time-consuming professional activities and allow him to use his professional skills much more productively. The focus in these endeavors is on community consciousness. The greatest investments will be in deliberate planning based on a belief in the rights of all citizens to have access to good health care. With modest expenditure, small communities can establish efficient emergency care through the use of everything from a pool of private automobiles to well-equipped ambulances or (with greater expense) helicopters. With prudent screening in each locality, advance arrangements can be made to have groups of patients seen with the least possible loss of time at the physician's office.

Consumer Health Education

One approach which has much merit in improving the rural health care problem is through a broadened program in consumer health education.

> The recent revival of interest in consumer health education is no accident. It is a highly appropriate response to recent developments in both the supply and demand for health care.
>
> With physicians and other health professionals overworked and harassed by myriad preventable health problems, with the costs of care rising astronomically and proving a burden to consumers finally beginning to realize that health cannot be bought or given to them through some magic potion, that they themselves bear the ultimate responsibility for their own health: the stage has been set for this belated but welcome revival.

The greatest untapped manpower resource in this country is the individual consumer. Needed is an informed and "activated" citizen who can take his own initiative in personal health—approaching and utilizing the health care system properly for all services required in his personal health management program.

An important and promising avenue for encouraging this appropriate, active response is through a broader program of consumer health education. For such a program to succeed, it must have an appropriate and high quality substantive base. This must be coupled with a pervasive delivery and access system that will assure widespread involvement and methods of effectively dealing with personal motivation.

Millions of Americans would benefit more from changing their dietary habits, losing weight, exercising, stopping cigarette smoking and cutting down or ending their consumption of alcohol and other drugs than from having more physicians and more hospitals available to treat them after their bad habits laid them low. State universities and land grant colleges are unique in their commitment to public educational service. Problem solving, research and education for all people with the objective of informed consumer action are major missions, not merely by-products of regular academic programs or of individual faculty and student actions. Extension has been the main outreach of these institutions, developing an ability to reach large numbers of people effectively, using the university resources in solving problems. Extension has considerable expertise in packaging information and using multiple teaching techniques. In addition, feedback mechanisms exist to measure the effectiveness of programs and the satisfaction of people being served. Other strengths include the ability to identify problems and needs, organize groups, and work with existing local power structures.

We must get people involved in their own health and concerned about the problems in their own communities. People have to become interested and confident in solving health problems—those problems they themselves define, not those imposed upon them from a national crisis concern. Several alternatives must be scanned and the cost and consequences of each considered. In essence, the way to better health must be made easier so people will make an effort to achieve it for themselves and their communities.

One of the answers is for the Extension services to be the center of new partnerships among diverse expert groups already working in other areas of the community—to bring them together so they work as a unit on a mutually agreed upon problem. Such groups can include physicians, other area health personnel, educators, law enforcement and public service organizations, private industrialists, clergy and, above all, concerned citizens who will be the motivating force at the laymen level.

Since most of the causes of the rising death rates among young men are related to life-style rather than the kind of health care they are, or are not, receiving, it is nonsense to blame the health professions. On the other hand, it is increasingly clear that there is no demonstrable causal relationship between increased expenditures for health care, or even increased health care personnel, and improved national health status.

The missing ingredient appears to be the active understanding and cooperation of the consumer-patient. And this is where health education must be mobilized—must be made part of the average physician's armamentarium and the average hospital's routine procedures.

Closing the Gaps

Let us remember that there are way to close the gaps in providing health services for rural people.

1. There is need to place continued and increased emphasis on family practice programs in medical schools.
2. The development of quality family practice residency programs must have much greater state and federal support.
3. Support and assistance should be given to programs that would increase the number of medical school graduates who have a rural background.
4. Establishment of group practice is one potential means of attracting physicians to rural communities. Availability of a suitable group practice opportunity is not only important in attracting a physician, but it is apparently important in retaining him.
5. Resources must be sought to develop and implement comprehensive continuing medical education programs for rural physicians.
6. Physician recruitment in rural America could be aided by a central clearinghouse. Conceptually, this could involve obtaining profiles for selected interns, residents, and other physicians desiring to select a new practice site, while at the same time obtaining profiles for recruiting regions. Physicians and regions could then be matched based on certain areas of common values.
7. Multiple rural communities in a logical health service area should plan together and develop health care systems on a regional basis. With a broader base of population and resources, the region could attract and be able to support the needed physicians, allied health professionals, and other resources.
8. Education for rural health is a fundamental aspect of community health services and is basic to every health program. Given the present demand in health care, a major effort directed at consumer health education should receive high priority. This is particularly essential in rural areas where health manpower is most limited. The greatest untapped manpower resource in this country is the individual consumer. Needed is an informed and "activated" citizen who can take his own initiative in personal health management program.
9. Health Science Schools must relate to community needs. They should give their students a wide variety of scientific and community experiences to allow them to make an informed choice for lifelong career. There must be more effort to teach health science students how to function as members of a health team within a health system.

10. Consumer groups and individuals should assume their citizenship responsibility to ensure that their elected representatives truly represent them in government halls. They should be sensitive to their own responsibility to plan for themselves and their community, to assume personal responsibility for learning good health practices and appropriate use of health resources.

All of us must recognize that "health does not exist in a vacuum." Health is but one aspect of the "quality of life" which includes all the socio-economic, ecological, and educational factors which make for a satisfactory living situation. To improve rural health we must also address the totality of deficiencies in rural living today.

We reiterate that rural physician recruitment has proven to be very difficult.

To summarize, several suggestions are: 1) for the physicians in the community to lead the recruitment effort (if no physician practices in the community, several outstanding citizens should assume this role); 2) if the community does not have the financial and population resources for successful recruitment, they should make every effort to reduce the burdens they place upon the rural physicians; 3) make an inventory of the health needs and community resources; 4) prepare a fact sheet about the area; and 5) contact physician placement services, medical schools, teaching hospitals and advertise the needs for medical personnel.

One thing is clear from our past experiences in developing models for health care services. Behind all success is generally one man—usually a physician or a small group of men—a medical society or hospital board—that have the creative intelligence—the vision to see what can be—and the strength to make it happen.

It seems to us that there is still time, indeed we must still have time to experiment in the development for models for rural health care. This country is so diverse geographically, economically, culturally, that to be locked into one rigid system would be self defeating. We still need to learn how rural-urban health system relationships can best be developed. We need to recognize the uniqueness of communities and give them frameworks in which their uniqueness can best be served. This can be done only by total involvement of all segments of the community in developing appropriate health service systems.

We are grateful for the opportunity to share with you all our concerns and our dreams for the betterment of health for rural Georgia. ■

HAWAII TOUR SPONSORED BY MAG IN '75

MAG will sponsor an 11-day tour to Hawaii in November-December 1975 in conjunction with the AMA clinical convention. All MAG members will receive a letter with the details on this after the first of the year.

The tour agency is American International Travel Service (AITS). Should you receive a solicitation from any other source for a trip to Hawaii, you should know that such would not be for an MAG-sponsored trip.

POSTGRADUATE COURSES HIGHLIGHT AMA'S PORTLAND CLINICAL CONVENTION

The Medical Association of Georgia will have a suite available for delegates and other members attending the AMA's 28th Clinical Convention in Portland, Oregon, November 30-December 4. The suite will serve as a meeting place for the delegation and should be considered your headquarters while in attendance.

Upon arriving in Portland, contact J. Rhodes Haverty, M.D. or Jim Moffett at the Portland Hilton for the exact location of the suite.

The 1974 clinical convention is designed to provide both educational review as well as scientific update and will feature many postgraduate courses that have been popular at recent AMA meetings. Credit toward the Physicians Recognition Award may be earned at many of the sessions, held primarily at Portland Memorial Coliseum.

The 16th National Conference on the Medical Aspects of Sports, held in conjunction with the convention, will include a luncheon with Jesse Owens as guest speaker. An independent program called "Fireside Forum" will include speakers from Chicago's Rush Medical School on current diagnosis and management of alcoholism. Physicians from the University of Chicago Medical School will conduct a forum on concepts in diagnosis and management of rheumatoid arthritis.

Other course topics include: critical patients—critical decisions, pediatric emergencies, cardiopulmonary resuscitation, coronary artery bypass, obesity management and human sexuality.

The Woman's Auxiliary to the AMA has scheduled for the first time a mixture of both scientific and social activities during the clinical convention. Auxiliary members will see the Pittock Mansion, Forestry Center and Oregon Primate Center in the "City of Roses" and can attend scientific programs on human sexuality and post-mastectomy breast reconstruction.

The familial, congenital and genetic aspects of this condition are discussed.

New Observations Concerning Vesicoureteral Reflux

WILLIAM J. MORTON, M.D., *Chamblee**

THE ETIOLOGY, PATHOGENESIS, and treatment of vesicoureteral reflux remains a highly controversial and debated topic among urologists. Each practitioner has his own feelings regarding reflux and the approach to each patient is also very individualized according to the multifactorial circumstances involved. The purpose of this paper is not to stir up a hornet's nest of opposing theories, but rather to alert those physicians dealing with urinary tract infections and therefore the possibility of vesicoureteral reflux, of another factor, i.e., familial vesicoureteral reflux. Regardless of the etiology and pathogenesis of reflux in each particular patient, the physician who will admit to the possibility of familial reflux will find undiagnosed cases and avoid the ever present danger of loss of renal substance. Urinary tract infection, enuresis, neurogenic bladder, and anatomical deformities (meatal stenosis) can all be associated with vesicoureteral reflux. Our present knowledge has expanded enough to include a voiding cystogram in addition to the intravenous urogram for evaluation of the patient. The asymptomatic patient must also be investigated for vesicoureteral reflux wherein documented reflux has been noted in siblings.

Observations and Hypothesis

The terms congenital, familial, and hereditary are not to be confused. Many diseases fall into each category. Exstrophy is congenital but is not hereditary. Diabetes mellitus and essential hypertension are familial but not hereditary nor necessarily congenital. Color blindness is usually familial, hereditary, and congenital. The question of vesicoureteral reflux is unresolved. Burger and Smith state that the incompetent ureteral orifice is familial, hereditary, and congenital, based on their observations in five families within their own practice as well as reviewing 10 other families who had reflux. I believe the hereditary and familial aspects of vesicoureteral reflux have been insufficiently studied. There has been no real evidence for autosomal or sex-linked inheritance. Mobley noted an incidence of from 2.8 per cent to 20 per cent of all patients with vesicoureteral reflux to be familial. The etiology of vesicoureteral reflux can be based on single or multiple components. Infection, outlet obstruction, abnormal position of the intramural ureter, inherent muscle wall weakness, and previous surgery can all be associated with vesicoureteral reflux. Based on these factors, treatment will vary as will be seen in the following patients.

Case Reports

Mrs. E. B., age 38, was originally seen by me with the history of years and years of recurrent urinary tract infections with left costovertebral angle pain. She had known pyelonephritis in one kidney. There was no past history of having a cystogram. A complete urological investigation revealed massive bilateral vesicoureteral reflux, bilateral chronic pyelonephritis with severe chronic atrophic pyelonephritis on the left side. She underwent a bilateral ureterocystostomy and follow-up x-rays, nine months post operative, revealed no evidence of vesicoureteral reflux with no significant change in the upper tracts.

The history was obtained on one daughter having known reflux and because of this, all members of the family (except the husband) were evaluated.

M. B., a daughter, age 10, had known total left vesicoureteral reflux four years previously with subsequent upper and lower urinary tract infections. No urological evaluation had been performed since the original investigation. A cystogram revealed total vesicoureteral reflux, bilaterally and the intravenous pyelogram was essentially normal. The patient underwent bilateral ureterocystostomies uneventfully and follow-up x-rays nine months later were all normal.

C. B., a daughter, age 13, was completely asymptomatic urologically and on urography was noted to have subtotal left vesicoureteral reflux with a normal intravenous pyelogram. Uroscopy revealed some

* Embry Hills Medical Center, 3646-F Chamblee-Tucker Road, Chamblee, Ga. 30341.

mild trigonitis and urethral stenosis. A urethral dilation was performed. A follow-up cystogram six months later was normal.

W. B., a son, age 5, was completely asymptomatic and a cystogram revealed total left vesicoureteral reflux without pyelocaliectasis and in addition, a right periureteral diverticulum which became evident on voiding. Cystoscopy revealed a significant meatal stenosis, a mildly laterally positioned left ureteral orifice, and no evidence of the paraureteral diverticulum. A urethral dilation and meatomy was performed. A follow-up cystogram seven months later revealed subtotal left vesicoureteral reflux and no evidence of the paraureteral diverticulum. Clinically, he has had no signs or symptoms of urinary tract infection. Follow-up x-rays are planned.

W. B., a son, age 15, was completely asymptomatic and a cystogram revealed significant bilateral paraureteral diverticula on the filling cystogram. There was no evidence of vesicoureteral reflux. Retrograde urethrogram and cystourethroscopy revealed no infravesical obstruction. Both diverticula were seen lateral and superior to the ureteral orifices. No infection was found. Both diverticula emptied well on voiding. A follow-up cystogram six months later revealed no change in the appearance of the diverticula. No surgical intervention is planned, unless signs or symptoms warrant it.

F. B., a daughter, age 8, is completely asymptomatic. Her cystogram revealed no reflux and only a question of a 2 to 3 millimeter accumulation of dye on the post-voiding film which may possibly represent a small paraureteral diverticulum. No cystoscopy or further follow-up has been performed.

Discussion

The obvious severity of pathology found in this family is apparent. Examples are seen of severe atrophic pyelonephritis, undoubtedly secondary to the long-standing vesicoureteral reflux and also massive vesicoureteral reflux with no significant damage to the upper tracts. Also, bladder diverticula with reflux is documented as well as bladder diverticula without reflux. I believe it is obvious that if the inherent bladder muscle weakness had not been present in the two children with the diverticula, more reflux and perhaps upper tract damage would have been seen.

The patients also portray the multiple approaches in the treatment of reflux, from radical to conservative. That is, the approach can be ureteral reimplantation, repairing outlet obstruction with bladder neck revision, urethral dilation, treating the infection with appropriate antibiotics, or simply "watchful waiting." In this family, several types of urological pathology were found in asymptomatic members because of the high index of suspicion. The investigation of all members of families wherein two or more members have proven vesicoureteral reflux is highly encouraged. The results of preventing renal parenchymal damage will be well worth the energy and expense involved. Data can also be gotten so that certain facts will be gathered and studied perhaps to be able to forecast the probabilities of reflux in other family members. The mode of transmission of reflux will surely be determined.

Summary

The familial incidence of vesicoureteral reflux ranges from 2.8 to 20 per cent of all patients with reflux. The familial, congenital, and genetic aspects of vesicoureteral reflux is discussed. A family is discussed in which a mother and daughter had severe enough reflux with its sequelae to warrant ureteral reimplantation. Two other family members have reflux and were treated conservatively. Two other cases of paraureteral diverticula were also noted. A plea is made for practitioners to investigate all members of a family with two or more members having reflux. Investigation of any other family member with a suggestive history of urinary tract infection or enuresis should be carried out wherein there is one documented finding of vesicoureteral reflux. ■

Addendum

Since this paper was originally written, W. B., age 5, had a repeat voiding cystourethrogram which revealed persistence of the total left vesicoureteral reflux. The paraureteral diverticulum appeared to be slightly enlarged and because it was felt that upper tract damage needed to be averted, a left ureteroneocystostomy was performed without incident. As of this printing the patient is approximately three weeks post operative and has done very nicely.

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Hoarseness and a Cystic Mass in the Neck

LEWIS GAYDEN, M.D. *and* PATRICK PEAVY, M.D., *Atlanta**

DR. LEWIS GAYDEN: This patient is a 54-year-old male with a history of hoarseness and recent onset of respiratory difficulties. His respiratory distress suddenly became severe and he was brought to the Emergency Room where he had a respiratory arrest. A tracheostomy was performed.

This is a lateral film of the neck for demonstration of laryngeal structures. Dr. Peavy, would you comment on this film?

Dr. Patrick Peavy: How long had the patient had symptoms?

Dr. Gayden: The patient had symptoms for two to three weeks and was on antibiotic treatment for an inflammatory mass in the right neck.

Dr. Peavy: This lateral film of the cervical spine presents signs of obstruction in the upper airway. An air/fluid level superimposes the region of the larynx and the upper airway, the structures above the larynx are well defined and appear normal. A tracheostomy tube is present. The air/fluid level overlying the larynx could represent secretions pooled above the obstructing lesion in the larynx, however, an abscess cannot be excluded on this lateral film. Are frontal films available?

Dr. Gayden: We have AP tomogram films of this area; what do these show?

Dr. Peavy: There is a mass confined to the area above the true cords. There is a soft tissue mass containing air which is markedly bulging into the right side of the vestibule of the larynx. The upright tomograms demonstrate an air/fluid level in this structure. The true cords of the larynx do not appear involved; however, the false cord on the right appears distorted by this mass. This appearance suggests the possibility of a laryngocele which has become infected, rather than a large abscess.

Dr. H. S. Weens: I believe that you are right. I believe that this patient had a laryngocele which became infected similar to pre-existing bullae of the lung which became secondarily infected. Is it pos-



FIGURES 1A, 1B

AP tomograms of the larynx showing the extent of the laryngocele.

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, Georgia 30322. The conference material has been edited by Doctors J. L. Clements and H. S. Weens.

sible for a pre-existing laryngocele to accumulate fluid without being infected?

Dr. Arthur Mazyck: Mittenmier, in his textbook, indicates that fluid accumulation can occur in laryngoceles without infection. This must occur rarely, however.

Dr. Patrick Peavy: Doesn't the nature of this structure preclude the possibility of fluid accumulation?

Dr. Mazyck: This laryngocele does have a dependent portion and it is lined by mucus membrane which could secrete mucus.

Dr. Gayden: This lesion was surgically treated with excision of the laryngocele. The final diagnosis was infected right intrinsic and extrinsic laryngocele.

Discussion

Laryngoceles are abnormal saccular dilatations of the appendix of the laryngeal ventricle of Morgagni forming an air sac lined with epithelium which maintains its communication with the ventricle by means of a narrow stalk.

If this ventricular appendage increases in size, it extends medial and superior to the thyroid cartilage until it reaches the *thyro-hyoid* membrane. At this point, there are three possible developments:

A. If the appendage pierces the membrane, it becomes an *external laryngocele*.

B. If the appendage remains confined within the membrane, it persists as an *internal laryngocele*.

C. The membrane acts as a narrow waist with the laryngocele assuming a dumbbell configuration with external and internal components. This is the *mixed laryngocele*.

For the development of laryngoceles several underlying factors come into play. One prerequisite is a longer than usual appendage. Since these occur in middle age, tissue changes associated with aging may play a role. Functional factors such as coughing, which increases the intra-laryngeal pressure are also important.

Laryngoceles are usually unilateral. Symptoms depend on the type of laryngocele and range only from a mass in the neck (external) to hoarseness and dyspnea (internal). ■

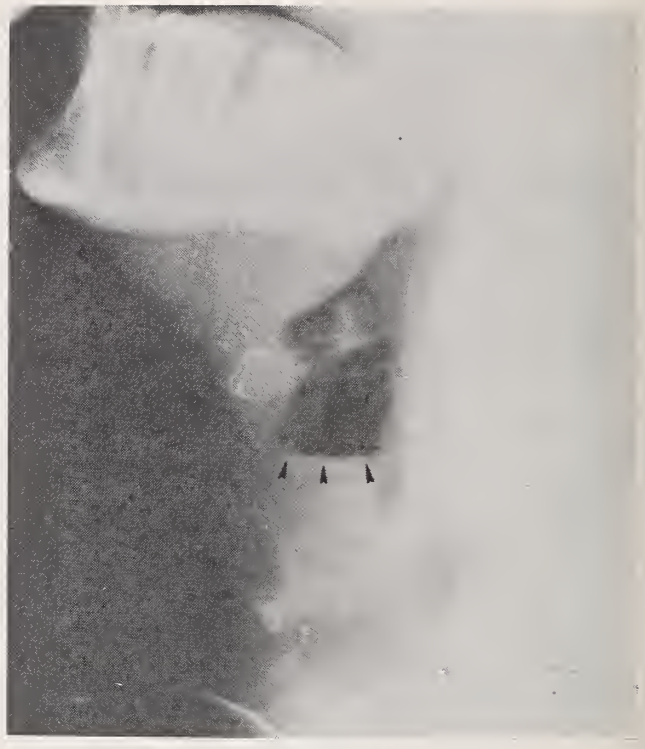


FIGURE 2

Lateral upright film of neck showing a fluid level in the large laryngocele.

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A REMINDER ABOUT THE FOUNDATION'S REVIEW PROCEDURES

It has been brought to the attention of MAG that many physicians are unaware of the Georgia Medical Care Foundation's review procedures for handling Medicaid claims.

Hospital and physician claims which exceed certain parameters are reviewed by the Foundation for medical necessity and quality of care. These claims are screened by administrative personnel, and those claims requiring further review are considered by individual physician consultants, specialty panels or the MAG Peer Review Committee as necessary.

In any instance in which the Foundation recommends to the state Medicaid agency that a claim be reduced or denied, the provider of services—physician, hospital or both—is so notified in a letter from the Foundation with an explanation of the recommendation for reduction.

If your Medicaid claim has been reduced or denied, you are urged to appeal such an action by writing to the state Medicaid agency, with a copy to the Foundation, requesting that the claim be reconsidered. You should do so particularly if you do not receive an explanation for the reduction from the Foundation. The appeal will help prevent reductions on the basis of inadequate information.

The Foundation was created by MAG to serve the physicians of Georgia in their dealings with third party payors, including the government and private insurance companies. You are encouraged to use the Foundation at any time you have difficulty with Medicaid claims, or with any other third party action on your claims.

Management and More—MAGNET 74

JUST AS THERE IS NOTHING wrong with a physician charging and collecting for services rendered, there is nothing wrong with applying good management techniques in the running of a medical practice. Good management is essential and the doctor who ignores sound business practices may soon find himself in trouble with the government.

Basic errors in practice management often can limit the number of patients a doctor sees in a day. With increasing pressure from the IRS and various peer review organizations, the need to maintain sound, well-documented records becomes more and more important.

When you expend large sums of money for personnel, office systems and financial planning, you need to know if your results are commensurate with your costs. This is what MAGNET 74 is all about.

MAGNET will be held at the new and exciting Fairmont Hotel in Atlanta, November 9-10, 1974. The conference will key in on the important practice management issues that face modern solo or group practices.

Topics included will be personnel administration, medical administration, office facilities and equipment, group practices, estate planning and many others. It is a power-packed session open not only to the MAG member but to your accountants, attorneys, business managers and any others you think might benefit.

We will have two medical management experts to lead us through the conference with plenty of time to ask questions and provide your input.

Due to inflation and the opening up of the conference to non-physicians there will be a small registration fee to help defray expenses. More information on this and the complete program will be coming to you soon.

Please block off the weekend of November 9-10 for this outstanding meeting.

Membership

WITH PSRO, HMO, NATIONAL HEALTH insurance and the many other things that concern medicine today, it is no wonder that we are being drawn closer to our professional organizations. Very obviously that is one of the many reasons we join groups like the MAG, to have that collective voice that can rise above the hue and cry.

Those members of medical associations who are involved in their activities can readily express the value of membership just in services alone. But what about the non-joiner, the person who doesn't care or is uninformed? It is to those people this article would be best addressed.

Whenever leaders of our association gather, the subject of membership seems to arise. Not just the question of how to attract new members but what services should we provide, how much should we be involved in continuing education and how do we improve the lines of communications to be of better service?

In the past we have apparently assumed that if a new doctor asked to be

a member he was interested and if he didn't ask he was not interested. This is no longer, if it ever were, good enough. There are obviously too many demands on our time to assume anything anymore. We have to become more aggressive in our recruiting efforts.

Some of the things we have been doing are: establishing liaison with the State Board of Medical Examiners, giving us direct access to new doctors that enter the state by examination or reciprocity; direct mail program to attract interns and residents; contact with the AMA for its lists and other resource services and making contact with members who have dropped out for one reason or another.

We have seen some degree of success as our overall membership has increased by 214 since the first of the year, bringing the total as of September 1 to 4,087.

If we are going to continue to grow and provide a needed service to the physicians of Georgia, we need to have new members with fresh ideas and a willingness to work for the betterment of all.

The Medical Association of Georgia has hired an educational coordinator to assist in the planning of continuing education programs. This offers exciting prospects for member physicians and should be a good benefit for prospective members. Of course, we are aware of the fine insurance programs sponsored or endorsed by the association as well as our legislative efforts on the state and national levels.

Joseph M. Almand, Jr., M.D.
Chairman, Committee on Membership

Letter to the Editor

(Ed. note: MAG has consistently opposed the forced inclusion of any provider of medical or health care in any insurance policy written or issued in Georgia for two primary reasons. First, it violates the right of contract by forcing terms and conditions which may not be acceptable to the contracting parties; and secondly, it tends to escalate artificially costs of care.

The MAG Executive Committee of Council is on record in favor of insurance payments to psychologists for services rendered only when the patient is referred to him by a physician.)

Dear Editor:

In regard to H.B. 2001, Psychologists Under Insurance, I would like to bring a correction to the attention of the MAG membership.

This bill was unfortunately amended by the introducing legislator without consultation of the Georgia Psychological Association to read that we were seeking coverage in **all** insurance policies.

Quite to the contrary, we have stressed that psychological services only be covered in policies **already** containing mental health provisions—and moreover that only such psychological services would be covered which specifically relate to nervous and mental disease as designated in the policy, and within the licensed scope of the psychologist to perform.

To my knowledge, this bill was studied and approved by a Mental Health Committee composed of psychiatrists set up by MAG as we took pains to bring the bill to the attention of Executive Committee of Council and met with them last year.

We were consequently disappointed when MAG decided to oppose the bill and disturbed over how the bill was amended so as to practically insure its languishing in the Insurance Committee.

The Georgia Psychological Association continues to urge the closest kind of collaborative interchange between its practicing members and physicians in the community.

Extending mental health benefits in insurance to cover for the clinical services of psychologists is meant as a benefit not only for the patients, not only for the integrity of the practice of the psychologist, but for the support of the physician who makes the referral to a psychologist.

In daily practice, the relationship of the physician and psychologist continues excellent. Psychologists continue to be a part of medical schools and are in the mainstream of research and practice. Our theoretical structure is within the scientific mainstream and we are not a splinter group in that sense.

We surely realize the problems of control and autonomy medicine is experiencing at this time. Our hope is to work alongside in a fruitful relationship.

John J. Mallet, Ph.D.

Immediate past chairman of the Georgia Psychological Association Committee on Health Insurance and president-elect of the GPA.

Is He a Source of Information?

Yes, with certain reservations. The average sales representative has a great fund of information about the drug products he is responsible for. He is usually able to answer most questions fully and intelligently. He can also supply reprints of articles that contain a great deal of information. Here, too, I exercise some caution. I usually accept most of the statements and opinions that I find in the papers and studies which come from the larger teaching facilities. It goes without saying that a physician should also rely on other sources for his information on pharmacology.

Training of Sales Representatives

Ideally, a candidate for the position as a sales representative of a pharmaceutical company should be a graduate pharmacist who has a questioning mind. I don't think this is possible in every case, and so it becomes the responsibility of the pharmaceutical company to train these individuals comprehensively. It is of very great importance that the detail man's knowledge of the product he represents be constantly reviewed as well as updated. This phase of the sales representative's education should be a major responsibility of the medical department of the pharmaceutical company.

I am certain that most of these companies take special care to give their detail men a great deal of information about the products they produce—information about indications, contraindications, side effects and precautions. Yet, although most of the detail men are well informed, some, unfortunately, are not. It might be helpful if sales representatives were reassessed every few years to determine whether or not they are able to fulfill their important function. Incidentally, I feel the same way about periodic assessments of everyone in the health care field, whether they be general practitioners, surgeons or salesmen.

Value of Sampling

I personally am in favor of limited sampling. I do not use sampling in order to perform clinical testing of a drug. I feel that drug testing should rightly be left to the pharmacology researcher and to the large teaching institutions where such testing can be done in a controlled environment.

I do not use samples as a "starter dose" for my patients. I do, however, find samples of drugs to be of value in that they permit me to see what the particular medication looks like. I get to see the various forms of the particular medication at first hand, and if it is in a liquid form I take the time to taste it. In that way I am able to give my patients more complete information about the particular medications that I prescribe for them.

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capacity they are indeed useful; particularly in the fact that they disseminate broadly based educational material and serve not just as "pushers" of their drugs.

The Other Side of the Coin

Obviously, the pharmaceutical companies are not producing all this material as a labor of love—they are in the business of selling products for profit. In this regard the ambitious and improperly motivated sales representative can exert a negative influence on the practicing physician, both by presenting a one-sided picture of his product, and by encouraging the practitioner to depend too heavily on drugs for his total therapy. In these ways, the salesman has often distorted objective reality and undermined his potential role as an educator.

The Industry Responsibility

Since the detail man must be an information resource as well as a representative of his particular pharmaceutical company, he should be carefully selected and thoroughly trained. That training, perforce, must be an ongoing one. There must be a continuing battle within and with the pharmaceutical industry for high quality not only in the selection and training of its sales representatives, but also in the development of all of its promotional and educational material.

The industry must be ready to accept constructive as well as corrective criticism from experts in the field and consumer spokesmen, and be willing to accept independent peer review. The better educated and prepared the salesman is, the more medically accurate his materials, the better off the pharmaceutical industry, health professionals and the public—*i.e.*, the patients—will be.

Physician Responsibility

The practicing physician is in constant need of up-dated information on therapeutics, including drugs. He should and does make use of drug information and answers to specific questions supplied by the pharmaceutical representative. However, that information must not be his main source of continuing education. The practitioner must keep up with what is current by making use of scientific journals, refresher courses, and information received at scientific meetings.

The practicing physician not only has the right, but has the responsibility to demand that the pharmaceutical company and its representatives supply a high level of valid and useful information. I feel certain that if such a high level is demanded by the physician as well as the public, this demand will be met by an alert and concerned pharmaceutical industry.

From my experience, my impression is that sectors of the pharmaceutical industry are indeed ethical. I challenge the industry as a whole to live up to that word in its finest sense.

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

P·M·A

president's letter

Clearly Drawn Lines



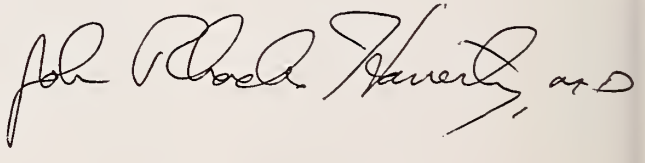
LAST MONTH ON THIS PAGE I summarized how the MAG presently is structured politically and mentioned the various uncoordinated modes by which "policy" is established for our organized medicine in Georgia. When this page is read, a group of us, including the Executive Committee, the Reorganization Committee, and the presidents and secretaries of the district societies will have met for two to three days at Unicoi to discuss both these issues.

I recognize and expect that the recommendations coming out of these meetings will be discussed further and refined by other groups. Eventually there will evolve a more orderly and efficient organization which will function effectively in anticipation of and reaction to the changing times and needs of our state.

One issue to be debated will be the organization of the staff of the headquarters office. Presently duties and functions are distributed too unequally. Confusion and inefficiency result. A management group consisting of three associate executive directors, each responsible for a segment of MAG activities, reporting to the executive director might be better. The three areas might be entitled Administration, Education, and Medical Services. Each MAG committee and activity (including such activities as GRMP, Research and Development, and the Georgia Medical Care Foundation) would relate to and through one of the Associate Executive Directors to the officers, Executive Committee, Council, and House of Delegates. The rest of the staff would be related similarly, according to their functions and activities.

Thus lines of authority would be drawn more clearly, and the concerns about who speaks for the MAG on which issues might begin to be addressed. In addition, reorganization of the governing bodies themselves will be discussed: their size, representation, and relationship to each other.

Because of the changing times; because of the changing needs of our members and of society; because we are growing in numbers, in scope, in activities, in influence, and in expectations, we must change ourselves in order to meet these challenges successfully.



John Rhodes Haverty, M.D.
President, Medical Association of Georgia

Mastectomy, Yes, But Which One?

PART II: TYPES OF MASTECTOMY

JOHN P. WILSON, M.D., *Atlanta**

IT WOULD BE PRESUMPTUOUS to imply that there is an "only" proper operation for breast cancer and perhaps pretentious to suggest that there is even a "right" operation for treatment of breast cancer. Probably more important than the option of operation is the need for both surgeon and patient to have a thorough understanding of the advantages and disadvantages of alternatives and reasons for the choice.

There is no evidence that any therapy carries a higher cure rate than the *classical radical mastectomy* when applied with reasonable criteria of operability. The mortality from radical mastectomy is essentially zero and other methods of treatment must be measured against the result of this operation. There is no hard data indicating that removal of the nodes with radical mastectomy affects the immune response significantly. The primary question is whether radical mastectomy offers any additional cure compared to simple or modified radical mastectomy, or if the difference in improvement is great enough to warrant the additional morbidity of the operative procedure.

On a larger scale the same may be said of the *super radical mastectomy* which includes resection of the internal mammary nodes. On the basis of Urban's results one must include super radical mastectomy as an alternative method of treatment although there is generally disenchantment with this procedure among most surgeons.

Modified radical mastectomy has been advocated and utilized increasingly more frequently. It has been stated by some that its greatest usefulness is in the elderly patient. It has been our experience that it is much more useful in the younger person where the cosmetic, as well as the functional result of preservation of the pectoral muscles is more important. The presumption that a modified radical mastectomy is a less extensive or time consuming procedure than the classical radical mastectomy is probably not justified.

Standardize Nomenclature

There are several operations which are done as modified radical mastectomies. It is important to standardize the nomenclature. A complete axillary dissection is implied in modified radical mastectomy, the only difference between modified and classical radical mastectomy being the preservation of the pectoral muscles in the latter operation. Theoretically, the compromising feature of this operation is the possibility of leaving involved intra-pectoral nodes in the modified operation. Practically there is some evidence that it does, at times, compromise the thoroughness of the axillary dissection. Some surgeons include the removal or severance of the pectoralis minor in the dissection. While this may improve the possibility of

* Chairman of the Board of Directors of the American Cancer Society, Georgia Division. Dr. Wilson is in practice at 340 Boulevard, N.E., Atlanta, Ga. 30308.

including intra-pectoral nodes, it also increases the possibility of disturbing or destroying the anterior thoracic nerves and thereby producing postoperative problems comparable to classical radical mastectomy.

Extended simple mastectomy is a term which should be applied to that operation which includes total mastectomy and removal of the major group of nodes from the axilla without a formal axillary dissection. There may be, at times, little difference between this and the modified radical mastectomy but enough exists that differentiation should be made, the extended simple mastectomy implying primarily mastectomy with the removal of the bulk of the nodes from the axilla, while the modified radical mastectomy implies a total axillary dissection with mastectomy incontinuity.

Total mastectomy is becoming more popular as a term for simple mastectomy. The simple or total mastectomy should include complete removal of the breast and implies no attempt to remove nodes.

Partial mastectomy, which has also been called "lumpectomy" and other terms, is the removal of a portion of the breast tissue without an attempt to do a total mastectomy. Objections to the operation include the failure to remove tumor which has intra-mammary spread, as well as the nature of the multifocal origin of many breast cancers. Partial mastectomy certainly deserves investigation and evaluation but at the present time it must be identified as an investigative type of procedure, to be used in a well controlled protocol designed to study its effectiveness.

The only answer, perhaps, that we have at the present time, in the surgical treatment of breast cancer, is that which Dr. Fisher expressed in the end of his talk at the Atlanta Graduate Medical Assembly, "At the present time, because we do not know how to treat breast cancer, it is recommended that it be treated in the way felt best by the individual surgeon."

Because this does not answer the many questions that are raised, we would offer what we currently consider a reasonable therapeutic approach to breast cancer.

Reasonable Therapeutic Approach

For preinvasive carcinoma of the breast, total or simple mastectomy is adequate. In the young woman with Stage I of carcinoma of the breast a modified radical mastectomy or classical radical mastectomy is utilized. For the Stage II, a more extensive carcinoma of the breast, particularly with those with palpable nodes or those involving the pectoral muscles, classical radical mastectomy is performed.

For the elderly, or poor-risk patient, simple, or extended single mastectomy may be utilized.

Some basic deviations from these concepts which have been embraced by others include the use of subcutaneteous simple mastectomy for in situ carcinoma however at times covert invasive carcinoma may be present. Also it is essentially impossible to remove all breast tissue with the subcutaneous mastectomy.

Modified radical mastectomy is currently preferred by some on all operable carcinomas except where there is demonstrated extension into the pectoral muscles.

In evaluating the choice of operations for a given patient, it is well to appreciate one basic concept that is common to all surgical approaches to breast cancer. Even those persons advocating partial mastectomy and simple mastectomy as definitive treatment are designing their treatment on the basis of the concept that it is desirable to completely excise the tumor, the issue being then how extensive an operation is necessary to completely excise the disease and secondly what is the price that is being paid for some assurance of complete excision. We would emphasize also that any decision must necessarily depend on the physician's psychological and philosophical approach. We would suggest that any physician who assumes the responsibility for the surgical care of the patient with breast cancer must have a very profound and deep sense of standard of performance. He must be open to real consideration of the patient's desire and willingness to make alternatives clear

to the patient and he must be able to do all procedures so that he will be able to give a studied opinion and not elect an operation by default.

Now the surgeon is faced with a patient who presents herself with a lump in her breast, a copy of an article from *Vogue* magazine, a quotation from the "Today" show, and a preconceived idea of how she should be treated—not necessarily consistent with the surgeon's concept of the proper treatment of her particular tumor.

It would appear that the greatest benefit derived from the unfortunate public debate is that physicians have learned to appreciate more and more the necessity and benefit of thorough communication with their patients. ■

SRC PUBLICATION PROFILES HEALTH CARE IN THE SOUTH

While the debate on national health insurance rages in Congress, poor and rural Southerners continue to suffer and die from the lack of adequate health care in far greater numbers than other Americans.

For example, if the infant mortality rates in the South had been equal to the 1971 national average, 2,383 Southern babies would not have died; if black infant mortality rates in the South had been equal to white infant deaths, 3,408 black babies would have survived the first year of life.

For the first time, these and other health-related data have been compiled in a single publication for each of the 1,105 counties in the Southern region by the Health Task Force of the Southern Regional Council (SRC).

Some of the 29 categories related to health status and resources in these counties include demographic material such as percentages of persons below poverty levels, percentages of housing with inadequate plumbing facilities, rurality, infant and general mortality ratios, physician, dentist and nurse patient ratios, numbers of black physicians, hospital numbers and hospitalization utilization.

The report points out that a national study in 1972 examined infant mortality rates in light of various socio-economic factors, including family income. The study revealed a strong association between the risk of infant death and the lowest socio-economic group. The possibility of such risk ranged from 50 to 100 per cent higher in the less advantaged group compared with rates in the middle and upper class groups. Further, the study estimated that almost 50 per cent of the infant deaths in the lower socio-economic group were preventable.

The SRC regional health profile points out that infants are not the only victims of poverty-related disease. A 1972 HEW study used by the SRC Health Task Force in its profile revealed that of all persons within the sample having annual incomes below $5,000, 20.9 per cent had limitations of activity from chronic health conditions compared with 10.9 per cent among the total population. The low income group had 23.7 restricted activity days per person annually and 9.4 bed disability days. This compares to 15.3 restricted activity days and 6.3 bed disability days within the total population.

Copies of *Health Care in the South: A Statistical Profile* are available for $3.50 a single copy or $2.50 for 10 or more by writing the Southern Regional Council, 52 Fairlie Street NW, Atlanta, Georgia 30303.

The Southern Regional Council, which is nonprofit and nonpartisan, is approaching its 30th year as the South's oldest biracial research and action oriented organization devoted to the attainment of equal opportunity for all citizens in the region.

"WORLD'S SICKEST FAMILY" EXAMINED AT GAFP MEETING

The Georgia Academy of Family Physicians will hold its 26th annual scientific sessions November 14-17, 1974 at the Executive Park Motor Hotel in Atlanta. This year's program, "The World's Sickest Family," will explore problems of all members of "the family" demonstrating comprehensive care and the use of the problem-oriented medical information system. The use of a team approach to medical care and the use of alternate teaching aids will be utilized.

Included in the roster of speakers are Drs. Robert Rakel, Alex McPhedran, Ray Gifford, Edgar Haunz, Alex Robertson and Ken Walton. The program will conclude with a two-hour session on "Marital Counseling" with Dr. Clark E. Vincent of the Marital Health Clinic of the Behavioral Sciences Center of Bowman Gray School of Medicine in Winston-Salem, N.C. Dr. Vincent is the author of "Unmarried Mothers," "Sexual and Marital Health: The Physician as a Consultant," "Human Sexuality in Medical Education and Practice" and "Psychosocial Aspects of Medical Training."

The GAFP program has been approved for 30 prescribed hours of postgraduate education by the American Academy of Family Physicians.

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Coronary Angiography: A Valuable Tool

C. WALKER BEESON, II, M.D., *Savannah**

TWELVE YEARS AGO, when Sones and his associates described their initial experience with selective opacification and visualization of the coronary circulation, a new era in the diagnostic evaluation of the nation's number one killer, atherosclerotic coronary heart disease, was launched. The years since have witnessed widespread acceptance of the usefulness of this technique and, in fact, have seen it accepted as the standard with which all other diagnostic modalities are compared. The precise information so readily obtainable has produced a much better understanding of the disease and has been followed by the development and widespread use of bypass revascularization of the myocardium. With the enthusiasm which has attended this new diagnostic tool, there have developed facilities for its performance throughout the country.

Several Indications

The indications for coronary angiography have widespread acceptance. Few would question its necessity in evaluation of the patient with chest pain in whom the usual diagnostic modalities—history, stress electrocardiogram—leave doubts. The unnecessary long term anxiety, disability, and change in life style produced with an incorrect diagnosis makes precise evaluation of this type patient mandatory. Patients under consideration for surgical intervention for angina or ischemic syndromes must be evaluated. The evaluation of angina in the patient with aortic valvular disease requires it. There are a number of other less absolute, but commonly accepted indications.

As the procedure is uniquely useful in the evaluation of chest pain and ischemic heart disease, one naturally asks what is weighed negatively against these most useful benefits.

There is expense, but weighing this against the real cost of incorrect diagnoses and long term disabilities, it seems a quite reasonable one. Patient discomfort is ordinarily quite minor. There is little or no pain involved in the procedure. The hospitalization required is generally less than 48 hours.

Potentially Hazardous Procedure

The major concern is that it is a potentially hazardous invasive procedure. What are the potential hazards or risks? Complications include death, disabling morbidity, and non-disabling cardiac and non-cardiac problems. Disabling complications are principally myocardial infarction and cerebral embolism. Ventricular fibrillation, ventricular tachycardia, and significant bradyarrhythmias can ordinarily be handled promptly without sequelae and without interrupting the procedure. Non-cardiac complications include most commonly thrombosis at catheter entry site and

* Memorial Medical Center, Savannah, Ga. 31405. Prepared at the request of the Committee on Physician Education of the Georgia Heart Association.

post-catheterization bleeding. These, when handled appropriately, rarely entail long term disability.

How frequent are complications? How high is the risk? There are disparate reports in this regard with quoted mortality and morbidity figures varying widely. In reviewing the literature available some generalizations can be made. It appears that the "occasional" angiographer will encounter complications at an excessive rate. In the hands of the experienced, the complication rate is quite low. Serious complications tend to occur in the patients with more severe disease; fatal complications are extremely rare in the absence of significant coronary vascular disease. Mortality is less than 0.5 per cent. The incidence of myocardial infarction is less than 1 per cent; cerebral thromboembolism less than 0.5 per cent. Total serious morbidity and mortality is below 1 per cent. Local complications which generally have not led to long term morbidity have occurred at about 1 per cent.

Studies are done with facility for rapid attention and treatment for all emergencies. Systemic heparinization has appeared important in reducing complications. In the past it appeared that risk was greater with femoral percutaneous approach than brachial, but recent experience suggests this is eliminated by systemic heparinization. Minimizing the complexity of the examination to obtain only essential data is important.

Coronary angiography when done skillfully with meticulous attention to all safety factors is an invaluable tool with unrivaled benefit for indicated situations. ■

LIONS EYE BANK, ATLANTA OPENS AT EMORY

The Lions Clubs of Georgia have stepped up their war on blindness by opening a new eye bank in the Emory University Clinic, 1365 Clifton Road N.E., Atlanta.

Officially designated the Lions Eye Bank, Atlanta, the new bank serves as a clearinghouse for collection and distribution of human eye tissue to be used in corneal transplants. Eyes are obtained from deceased persons who, prior to death, have agreed to donate their eyes so that others might see.

The Lions Eye Bank, Atlanta, along with its sister eye bank at the Medical College of Georgia in Augusta, sends eye tissue to eye surgeons in Atlanta and throughout Georgia. The two eye banks are supported by the Georgia Lions Lighthouse Foundation, Inc.

According to Louis A. Wilson, M.D., medical director of the Lions Eye Bank, Atlanta, and associate professor of ophthalmology, Emory University School of Medicine, "The demand for eye tissue is great. Hundreds of Georgians now suffering from corneal blindness must wait for a cornea to become available for transplantation."

The Lions Eye Bank, Atlanta, is also involved in the training of licensed morticians in the removal of eyes from deceased donors to be shipped to the Lions Eye Bank, Atlanta, for use in corneal transplant operations.

Some living corneas are preserved for as long as a year in a new cryopreservation unit at Emory, which is also supported by the Georgia Lions Lighthouse Foundation. The corneal tissue is kept frozen at a temperature of minus-80 degrees Centigrade. The goal of eye researchers and physicians at Emory is to be able to use this new equipment more frequently so as to eliminate the present waiting problem of potential corneal transplant patients. If this were accomplished, surgery could be scheduled in advance and emergency corneal transplants could be performed quickly without waiting for donor eyes.

Information about donating eyes may be obtained from Janie Benson, eye bank secretary, the Lions Eye Bank, Atlanta, at (404) 377-2246 or by contacting local Lions Clubs throughout Georgia.

GEORGIA BAPTIST HOSTS HONORARY PEDIATRIC LECTURE

The Joseph Yampolsky Honorary Pediatric Lecture, entitled "Light and Bilirubin Today," will be presented by New York pediatrician Audrey K. Brown, M.D. at 8 p.m., Tuesday, November 12, 1974 in the Auditorium of Georgia Baptist Hospital.

MAG members are cordially invited to attend the lecture by Dr. Brown who serves as professor of pediatrics for the State University of New York. She is the physician in charge of pediatric hematology-oncology for Downstate Medical Center in Brooklyn, N.Y. and formerly held the positions of professor of pediatrics and director of pediatric hematology-oncology for the Medical College of Georgia.

legal page
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Qualified Retirement Plans Employee Retirement Income Security Act of 1974

(FINALLY)

ARMIN G. BRECHER, ***Atlanta****

PRIOR ARTICLES HAVE DISCUSSED the various proposals in Congress to change the laws governing tax-qualified retirement plans, which commenced as early as 1969. Finally, on September 2, 1974, President Ford, in an historic Labor Day ceremony, attended by many of the country's top government, labor and business leaders, signed what has been described as a landmark law, the Employee Retirement Income Security Act of 1974.

Affects All Retirement Plans

The following comments are of a general nature only and do not attempt to summarize all of the provisions of the bill which is 247 pages long and which was accompanied by an explanatory statement of the Conference Committee which is 136 pages long. Since this bill affects every qualified retirement plan in the United States and will effectively require that substantially all qualified retirement plans will have to be amended in one form or another, physicians should consult their attorneys, accountants or tax advisors with respect to the application of the bill to their qualified retirement plans and the changes which might have to be made in their plans as a result of the bill.

Because the bill substantially increases permissible Keogh or HR10 plan deductions, and also provides for income tax treatment of distributions from Keogh or HR10 plans to be identical to income tax treatment of distributions from corporate plans, it will be an important consideration for physicians in determining whether or not to incorporate in the form of a professional corporation. The following discussion, unless otherwise indicated, relates only to corporate plans, as opposed to Keogh or HR10 plans, since the only major changes with respect to Keogh or HR10 plans are in the areas of contribution limits, income taxation of distributions and fiduciary standards. Some of the principal features of the Employee Retirement Income Security Act of 1974 are:

1. Participation: Generally, all employees age 25 or more who have one year of service with a corporation are required to be covered, but if a plan provides that benefits are 100 per cent vested at the time an employee is covered, a plan may require three years of employment for participation. Maximum age exclusions are prohibited, except that a pension plan may exclude an employee hired within five years of his normal retirement age. For purposes of participation and vesting, one thousand hours of work constitutes a year of service, and all service with a company

* Prepared at the request of The Medical Association of Georgia. Mr. Brecher is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

must be counted, even though interrupted, with certain exceptions.

2. Vesting: A plan must provide that an employee's rights are nonforfeitable at normal retirement age and must also meet one of three alternative vesting standards in the event of termination of employment prior to normal retirement age. The following is a summary of those alternatives:

(a) A graded vested standard under which an employee must be at least 25 per cent vested after five years of service, with 5 per cent per year for each of the next five years, plus 10 per cent for each of the next five years; or

(b) 100 per cent after 10 years of service; or

(c) Vesting under the rule of 45 which requires that an employee with five or more years of service would be 50 per cent vested when the sum of his age and years of service totalled 45, with an additional 10 per cent per year vesting for each year of service thereafter. However, it would have to be provided that regardless of an employee's age, if he has 10 years of service, he must be at least 50 per cent vested, with an additional 10 per cent per year of service thereafter.

3. Limits on Benefits and Contributions: In the case of corporate pension plans, other than money purchase pension plans, there is an overall annual benefit limitation equal to the smaller of $75,000 or 100 per cent of the employee's average salary during his highest three consecutive years of compensation (not less than $10,000). With respect to employees participating in a plan as of October 2, 1973, there is an exception to the benefit limitation which provides that such an employee's pension need not be lower than the lesser of his annual salary rate on that date or his projected annual pension on that date, projected as if he would receive no further salary increases.

In the case of corporate profit sharing plans or money purchase plans, the annual addition for a particular employee may not exceed the lesser of $25,000 or 25 per cent of pay. "Annual additions" are the total of employer contributions, forfeitures, and the smaller of employee contributions in excess of 6 per cent of pay or one-half of the contributions made by such employee.

The limits on deductions for contributions to Keogh or HR10 plans have been increased. In case of a profit sharing or money purchase pension Keogh or HR10 plan, the limits on contributions have been increased to the lesser of $7,500 or 15 per cent of earned income of a sole proprietor or partner, on the first $100,000 of income. The same increased limits on deductions are applicable to shareholder-employees of Subchapter S corporations. In addition, guidelines are set up within which the Commissioner of the Internal Revenue Service may prescribe regulations which will make regular pension plans available to self-employed persons and such shareholder-employees. The regulations would be written in such a way as to convert the 15 per cent or $7,500 limitation into limitations on benefits which may be paid under a normal pension plan.

4. Income Taxation of Distributions: Lump-sum distributions made in 1974 and subsequent years will be taxed, with respect to an employee's percentage of participation in the plan prior to 1974, as a long-term capital gain, and with respect to the percentage of participation in the plan subsequent to 1974, as ordinary income. However, if an employee has participated in a plan for five or more years, he may elect to average the ordinary income portion over the next 10 years and will then be taxed on such under the tax rate schedule for single persons, without regard to other income. These new provisions for the taxation of lump-sum distributions are applicable to distributions by Keogh or HR10 plans, as well as to distributions made by corporate plans, which provides for a truly equal treatment of the taxation of lump-sum distributions made by such plans.

5. Funding: For pension plans, other than money purchase pension plans, which were in existence on January 1, 1974, past service liabilities may be funded over 40 years; and for such plans established after January 1, 1974, past service liabilities must be funded over no more than 30 years. In the event there is a funding deficiency, there is a 5 per cent nondeductible excise tax imposed in each such year

and in the event such deficiency is not corrected within a reasonable time after formal notice, a 100 per cent excise tax is imposed. There are many complex variations of the general rules set forth above.

6. Plan Termination Insurance: The termination insurance provisions are applicable only to pension plans, other than money purchase pension plans, and are administered by the Pension Benefit Guaranty Corporation, a new office in the Department of Labor. Each such plan must pay a per capita premium of $1 per participant. Insurance benefits for a particular employee are limited to the lesser of his average wages during his highest paid five years of participation or $750 per month. The employer, unless insolvent, would be liable to reimburse the Corporation for insurance payments made by it, up to 30 per cent of the employer's net worth.

7. Fiduciary Responsibility: An employer, in its administration of any type of plan, any investment or administrative advisor, the trustee, any administrative committee, and any other person who has any discretion with respect to a plan or investments by a plan are defined as fiduciaries. Fiduciaries must perform their duties so that a plan is administered for the exclusive benefit of the participants and their beneficiaries and are also subject to the rule that they must act with the care, skill, prudence and diligence which a prudent man acting in similar circumstances would act. A fiduciary is prohibited from directly or indirectly engaging in certain transactions with any persons who have an interest in a plan, their relatives, agents and any joint venturers with them. Effective January 1, 1974, any such person who engages in such prohibited transactions, which basically involve any transaction between the plan and such a party-in-interest, will be subject to a 5 per cent nondeductible excise tax on the amount involved for each taxable year of such transaction and for each subsequent year in which it is not corrected. If such transaction is not corrected after notice, such party-in-interest is subject to a nondeductible excise tax equal to 100 per cent of the amount of the transaction. In addition, fiduciaries are personally liable for any losses resulting from any breach of a fiduciary duty and are also liable for any profits which such fiduciary may have made through the use of a plan's assets. A co-fiduciary may be liable for the breach of fiduciary responsibility of another fiduciary under certain circumstances.

8. Reporting: No more than 120 days from December 31, 1975, a comprehensive, detailed plan description in the form of a summary written in understandable language must be furnished to each participant and beneficiary and a copy must be filed with the Secretary of Labor. No more than 210 days after each plan year which ends after January 1, 1975, annual reports are required to be filed with the Secretary of Labor, containing, among other information required, a financial statement prepared by an independent qualified public accountant and an actuarial report (in the case of pension plans other than money purchase plans) prepared by an enrolled actuary. Copies of such annual report must be available for inspection by participants and on written request, a participant can obtain a copy of such annual reports. If the plan administrator fails to comply with a request within 30 days, he is personally liable to the participant for up to $100 per day.

9. Enforcement: The Treasury Department and the Labor Department share in the administration and enforcement of qualified plans. Any person who willfully violates any provisions relating to reporting and disclosure may be fined not more than $5,000 or imprisoned for not more than one year, or both, except that a violation by an entity other than an individual, such as by a corporation or a union, may result in a fine up to $100,000. Civil actions may be brought by the Secretary of Labor, a plan participant or beneficiary or by another fiduciary in any federal district court where the plan is administered, or where the breach took place, or where the defendant resides or may be found. A co-fiduciary may be liable for the acts of another fiduciary under a number of circumstances.

10. Individual Retirement Accounts and Annuities: In order to provide persons

who are not covered by qualified plans established by their employers with some tax deductible retirement benefits, individuals and their spouses who earn income are permitted to deduct the lesser of $1,500 or 15 per cent of their compensation due to contributions to an individual retirement account or for an individual annuity or for an individual retirement bond. Individual retirement accounts can be established either as trusts or as custodial accounts and it is anticipated that the trustee or custodian will be a bank, although other types of organizations may act as trustees or custodians if they demonstrate their ability to administer such trusts or custodial accounts in accordance with the provisions of the law.

An individual retirement annuity also qualifies in a similar manner if it meets certain requirements and if the annual premium does not exceed $1,500. All accounts or annuities must require that the entire interest must be distributed to the participant no later than before the end of the taxable year during which the participant attains age 70½.

Generally, individual retirement accounts are exempt from income tax. An individual may not borrow money from the individual retirement account, or it will cease to be an individual retirement account which triggers a constructive distribution to the individual equal to the fair market value of all assets of the account as of the first day of the taxable year in which the loan was made. This amount is taxed as ordinary income.

All distributions are taxed as ordinary income and are not eligible for capital gain treatment or for the special averaging for lump-sum distributions from corporate or Keogh or HR10 plans. In addition, in the event any distribution is made prior to the time an individual becomes disabled or attains 59½ years of age, a 10 per cent penalty tax will be imposed. A distribution to the beneficiary of the owner of an individual retirement account or annuity will not be excluded from the owner's estate for purposes of federal estate taxes.

Tax-Free Roll-Over

A new concept known as a tax-free roll-over has also been introduced. This allows a tax-free transfer of assets from an individual retirement annuity or bond to an individual retirement account (or vice versa) and from a qualified plan to an individual retirement account or annuity. However, in the event of a roll-over from a qualified plan to an individual retirement account or annuity, the additional benefits available with respect to distributions from qualified plans, such as the benefits resulting from lump-sum distributions and the exclusion from estate taxes, in certain instances, are lost.

The foregoing is merely a brief summary of some of the major changes resulting from the Employee Retirement Income Security Act of 1974. Due to the fact that the bill includes over 60 requirements for new regulations, an enormous volume of Internal Revenue and Department of Labor regulations issued pursuant to the bill is expected. Until such time as those regulations are issued, either in proposed or in final form, many of the more technical provisions of the bill cannot be interpreted since the official regulations may, in some instances, vary from a common-sense approach under the provisions of the bill. As a result, it should again be emphasized that any doctor or group of doctors affected by this legislation should consult in detail with their attorneys, accountants and other tax advisors. ■

I've told this before . . . .

(Ed. note: Author J. G. McDaniel, M.D., comments that "This is an old story that I have told many times. I told it to my wife prior to our marriage and to many brides and wives over the years." Its startling conclusion leaves a strong impression. Others wishing to contribute to this page should send their papers to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

A Wife's Dilemma

Some 50 or 60 years ago, when trains were in their heyday, they were the chief means of transportation. Public roads were unpaved, rough, dusty or muddy depending on the weather. Traveling salesmen, known as drummers in those days, used the trains almost exclusively, as did other travelers.

Railroad men were a hearty lot. They worked long hours and ofttimes unusual hours. Many were thirsty and all were hungry.

Ben Beauchamp was such a man. He had started working as a switchman at 18 years of age. After some years of hard work he became a fireman. By this time he was well into his twenties and commenced looking around for a wife. He found an attractive and sensible girl by the name of Susie Mitchell and they were married after a short courtship. Some gossips said that Susie married Ben on the rebound, she had been going with a lawyer for about two years, when he up and married a girl from Atlanta. But that's beside the point.

They got along well together. Ben's pay was above average. His train left at 8 a.m. He fired his engine for four hours to another railroad town about 100 miles down the road. There he laid over a couple of hours and fired another engine back, usually getting home about 7 p.m. This was six days a week.

Susie and Ben were never blessed with children, but they were apparently doing quite well. They had bought a modest home and over the years Susie had added to its attractiveness with a piece of new furniture now and then and by enticing Ben to help her with flowers and shrubbery in the yard.

Then came a change in their routine. Ben was promoted to an engineer and his run was changed. Instead of leaving at 8 a.m. he now had to leave at 3:30 a.m., pull a passenger train, old 94, to the same place four hours down the road, lay over there five or six hours and bring another train back north.

And while this brought in more money and prestige, Susie did not like it. In fact, she told Ben positively that she was not about to get up at 2 a.m. every morning and cook breakfast six days a week, especially since Ben required and enjoyed and ate only two big meals daily.

That was the reason that Ben commenced eating breakfast at Red Rose's boarding house. It was known as this because the lady's name was Rose, she was redheaded and people fell into the habit of saying, "eating at Red Rose's." Rose was the widow of a brakeman who had been killed in a train wreck and she made a good living feeding mostly railroad men, especially these early breakfasts when nothing else was open. She closed at 2 p.m.

Ben got up every morning at 2 a.m., joined a good many railroad men and a few drummers who were going to ride the train. They all swapped tales and ate a hearty breakfast.

Some 10 years went by and Ben still clung to his routine: leave home at 2 a.m., back home at 7 p.m., six days a week. The only change that Susie could

notice was that he became more finicky about his appearance.

One afternoon Susie was attending a meeting of the WCTU when she commenced talking with a drummer's wife, and as the conversation progressed, it developed that her husband had ridden Ben's train many times and also loved to eat breakfast at Red Rose's place. She said that her husband got tremendously upset when they changed old 94's schedule from leaving at 3:30 a.m. to leaving at 8 a.m., and when this occurred Red Rose quit serving early breakfasts.

Somewhat stunned, Susie asked, "and when did all this take place?"

"Oh," was the reply, "Old 94, that used to leave at 3:30 going south hasn't run for at least five years. As I told you, it doesn't leave now until 8 o'clock!"

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Georgians Earn Physician's Recognition Award

Eighty MAG members are among the 126 doctors in Georgia announced as recipients of the 1974 Physician's Recognition Award of the American Medical Association. This group of winners qualified in the November 1973 to June 1974 period.

The Physician's Recognition Award was first offered in 1969 "to recognize, encourage and support physicians who participate regularly in continuing medical education and to emphasize the importance of developing more meaningful continuing medical education opportunities for physicians."

The award is granted for a minimum of 150 credit hours of continuing medical education activities earned over a three-year qualifying period. These hours, in turn, must be earned in several categories of learning experiences, such as courses taken from accredited sponsors and institutions, residency programs, authorship of books and articles, teaching, etc. Ten state associations, including Florida, Alabama and North Carolina, have adopted resolutions requiring continuing medical education as a condition of membership, and the American Academy of Family Physicians already has this requirement in effect.

The MAG members earning the PRA include:

Santiago Jose Aguilar, Milledgeville
Stanley Preston Aldridge, Decatur
Christopher John Allan, Marietta
Edwin W. Allen, Milledgeville
Lawrence L. Allen, Thomaston
Joseph Bedent Baird, Atlanta
Henry Jackson Baskin, LaGrange
Avery Patton Beall, Adel
Wiley Singleton Black, Gainesville
Arthur Stovall Booth, Atlanta
Howard Leon Bruckner, Augusta
Gerald Eugene Caplan, Savannah
Richard William Cohen, Austell
Robert William Crow, Atlanta
Hamilton Smith Dixon, Rome
Michael B. Feinerman, Austell
David Benton Fillingim, Savannah
Sumner Leon Fishbein, Augusta
John Edward Fowler, Clayton
Ned Martin Franco, Atlanta
Milton Frank, Atlanta
Murray Allen Freedman, Augusta
Harold R. Gertner, Atlanta
Bruce M. Gillett, Marietta
Armand B. Glassman, Augusta
William J. Gower, Thomaston
Melvyn Lawrence Haas, Augusta
Charles M. Hendricks, Dublin
Julio J. Hernandez, Baxley
William Slocum Howland, Atlanta
Henry Calvin Jackson, Manchester
Carl Jelenko, Augusta
Chester Wright Jenkins, Fort Benning
Jane Blakely Jennings, Savannah
Edwin Ladd Jones, Atlanta
Garland Frank Jones, Augusta
Thomas Eugene Kennedy, Buford
Ted Flournoy Leigh, Atlanta
Grady Estes Longino, Dublin
Max Paul Lorenz, Marietta
Malcolm N. Luxenberg, Augusta
William Cullen McCarver, Gainesville
Malcolm T. McGoogan, Waycross
Harold David Meltzer, East Point
Arthur Jesse Merrill, Atlanta
Byron Donald Minor, Decatur
Marvin Max Mitchell, Marietta
Charles Robert Moore, Moultrie
Byron Lamar Murray, Waynesboro
George Richmond Mushet, Augusta
W. Lanier Nicholson, Hiawassee
Clark Lamont Osteen, Savannah
Jorge Arturo Oteiza, Thomasville
George Robert Parkerson, Macon
Kenneth Edward Peirce, Columbus
Morgan Burgess Raiford, Atlanta
Robert Lee Raitz, Dalton
Drayton M. Sanders, Dalton
Philip Bryan Sapp, Dalton
Herbert Miles Schiller, Columbus
Elbert William Schmitt, Atlanta
Robert Orville Schoffstall, Macon
Perry Gray Seese, Atlanta
Stanley Terry Shapiro, Smyrna
Eloise Baim Sherman, Savannah
Vilda Shuman, Waycross
Robert Webb Simmons, Dalton
Robert Louie Smith, Augusta
Stuart Austin Smith, Rome
Olan Wytch Stubbs, Chamblee
John Render Turner, LaGrange
Max I. Viera, Dublin
Joe Martin Webber, Columbus
Edward Allen Weiss, Brunswick
Paul D. Weston, Augusta
John William White, Fort Benning
Michael Howard Whittle, Fort Gordon
Stewart Earle Wiegand, Atlanta
Leslie La Mar Wilkes, Savannah
George Fraser Williams, Atlanta

the association
the association
the association

NEW MEMBERS

Bernstein, Jeffrey A. MAA—Act—ObG	3312 Piedmont Rd., N. E. Atlanta, Ga. 30305
Bloom, William F. Bibb—Act—R	777 Hemlock St. Macon, Ga. 31204
Boatwright, Martha H. MAA—Act—P	80 Butler St., S. E. Atlanta, Ga. 30303
Bunnen, Robert L. MAA—A—Su	3312 Piedmont Rd., N. E. Atlanta, Ga. 30305
Curiel, Hector J. Cobb—Act—FP	Medical Building Dallas, Ga. 30132
Davis, Matthew E. Clayton-Fayette—Act—OALR	33 S. W. Upper Riverdale Rd. Jonesboro, Ga. 30274
Gilliard, Fred E. Coffee—Act—FP	Ward Street Douglas, Ga. 31533
Grossman, Gilbert MAA—Act—I	35 Linden Ave., N. E. Atlanta, Ga. 30308
Hagood, Murl F. Cobb—Act—Su	50 Plaza Way Marietta, Ga. 30060
Hug, Carl C., Jr. MAA—Act—Anes	60 Butler St., S. E. Atlanta, Ga. 30303
Jones, Charles M. MAA—Act—FP	80 Butler St., Box 26334 Atlanta, Ga. 30303
Kim, In Sook Carroll-D-Haralson—Act—I	201 Allen Memorial Drive Bremen, Ga. 30110
Kim, Pyung Jung Carroll-D-Haralson—Act—SU	201 Allen Memorial Dr. Bremen, Ga. 30110
Kirchner, Arthur B. MAA—Act—R	Grady Memorial Atlanta, Ga. 30303
Kleris, George S. MAA—Act—FP	99 Butler St., S. E. Atlanta, Ga. 30303
Lenton, John D. AA—Act—I	490 Peachtree St., N. E. Atlanta, Ga. 30308
Lynott, Marjorie A. Cobb—Act—FP	277 Fairground St. Marietta, Ga. 30062
Massey, Joe B. MAA—Act—ObG	960 Johnson Ferry Rd., N. E. Atlanta, Ga. 30342
Medina, Leonardo H. Clayton-Fayette—Act—U	217 Arrowhead Blvd. Riverdale, Ga. 30236
Napoli, Victor M. MAA—Act—Path	80 Butler St., S. E. Atlanta, Ga. 30303
Nunez, William D. MAA—Act—Anes	2760-B Felton Dr. East Point, Ga. 30344
Parungao, Romulo L. MAA—Act—Su	1235 Salen Gateway Conyers, Ga. 30207
Sanchez, Francisco R. Walker-C-Dade—Act—FP	LaFayette Med. Center LaFayette, Ga. 30728
Sathe, Anand J. Laurens—Act—ObG	105 Vernon St. Dublin, Ga. 31021
Smith, Nat E. Bibb—Act—I	Mercer University Macon, Ga. 31201
Souza, Renato C. Clayton-Fayette—Act—EM	274 Senoia Rd. Fairburn, Ga. 30213
Sung, Yung-Fong MAA—Act—Anes	Emory Univ. Hosp., Dept. Anes. Atlanta, Ga. 30322
Throne, Martin L. MAA—Act—I	3648 Chamblee-Tucker Rd. Chamblee, Ga. 30340
Tootle, Jerry C. Chattahoochee—Act—Su	P.O. Box 746 Duluth, Ga. 30136
Wolff, John McD. MAA—Act—I	1938 Peachtree Rd., N. W. Atlanta, Ga. 30309

SOCIETIES

Candidates for senator and representative to the Georgia General Assembly met with the **Bibb County Medical Society** September 4 and answered questions on their backgrounds and platforms. Society members Larry Freant, Bob Ireland and Milton Johnson recently have appeared on various Macon area television programs to explain and discuss health problems.

DeKalb County's successful project, Tel-Med, has prompted so many calls from the public that the number of incoming lines has been doubled to 20. The new lines are used to tell the overflow callers that they must call back at a later time. The project has been advertised by the sponsoring C & S National Bank in several national news magazines. The September 16 meeting of the DeKalb Society featured a program on "Medivest, Limited."

The September 10 meeting of the **Medical Association of Atlanta** at the Academy of Medicine was a discussion on "Current Concepts in Cancer Chemotherapy" with Benjamin Kahn, M.D., professor of medicine at Hahnemann University in Philadelphia and Richard Smalley, M.D., associate professor of medicine at Temple University in Philadelphia. An accompanying panel was composed of Lawrence E. Cooper, Norma Price and Stanley Winokur.

PERSONALS

First District

Frank Carlton, Savannah urologist, has been appointed to the Marine Fisheries Advisory Committee of the Department of Commerce. Dr. Carlton serves as president of the local Savannah National Coalition for Marine Conservation, made up of sport fishermen. Dr. Carlton is also the co-author of "Crossed Renal Ectopia," which appeared in the September *Southern Medical Journal.* Other co-authors were **Peter L. Scardino** and Alejandro D. Vargas, also of Savannah.

Gabriel Serrano has opened an office in the practice of general medicine in Savannah, coming from a position as chief of the medical staff at Evans Memorial Hospital in Claxton.

Second District

Tifton physician **Carl S. Pittman, Jr.** has been named to the board of directors of the C & S Bank of Tifton.

Fifth District

Dave McAlister Davis of Atlanta has been appointed to the Mental Health Advisory Board of the National Foundation for Sudden Infant Death, Inc. Dr. Davis received his medical and psychiatric training at the Universities of North Carolina and Florida, Harvard and Emory and serves as director of psychiatric services and adolescent treatment programs at Peachtree and Parkwood Mental Health Centers and Hospitals.

J. Willis Hurst, professor and chairman of the Department of Medicine at Emory University, participated in a postgraduate course sponsored by the University of Southern California in mid-August. September 7 he presented two scientific papers at the Seventh World Congress of Cardiology in Buenos Aires, Argentina.

John P. Wilson of Atlanta, associate chief of surgery at Georgia Baptist Hospital, spoke at the annual meeting of the Sumter County Unit of the American Cancer Society in Americus at the end of August. Dr. Wilson is chairman of the board of directors of the American Cancer Society, Georgia Division.

Seventh District

Grover Brown has moved his practice from Cartersville to Lindale.

William E. Dalton has opened an office in the practice of general medicine and obstetrics on South Wall Street in Calhoun. He came from El Paso, Texas, last February and has served in the emergency room at Gordon Hospital in Calhoun since then.

Fred Huie Simonton of Chicamauga has been named the Outstanding Alumnus for 1974 by the Fourth District A & M School, now West Georgia College, from which he was graduated in 1923.

DEATHS

Charles Swift Jones

Atlanta native, Charles Swift Jones, born August 27, 1917, died June 7 in Houston, Texas of histiocytic lymphoma.

Dr. Jones was graduated from Emory University in 1937 and Cornell University Medical College in 1941 and was a member of Phi Beta Kappa, ΑΩΑ, Chi Phi social and Phi Chi medical fraternities. His residency was completed in surgery at New York Hospital, following which Dr. Jones returned to Atlanta and the Winship Clinic. He entered private practice after one year at the clinic.

Dr. Jones was on the staffs of St. Joseph, Grady Memorial, Crawford W. Long and Piedmont hospitals, and was active in expansion programs for Piedmont as well as serving as chief of surgery at the time of his death. For several years he was chairman of the Insurance Committee of the Medical Association of Georgia and

ANDRE NAHMIAS WINS MEAD JOHNSON PEDIATRIC AWARD

Dr. Andre J. Nahmias, 44, professor of pediatrics at Emory University and one of the first scientists to link a viral infection to cervical cancer, has been chosen to receive the E. Mead Johnson Award for Research in Pediatrics, given annually by the American Academy of Pediatrics.

Dr. Nahmias was to receive the prestigious award, which includes a $3,000 honorarium and a sheepskin scroll, at the annual meeting of the American Academy of Pediatrics in San Francisco October 21.

He is being honored for original and significant contributions in the area of herpes simplex virus (HSV) infections, primarily those due to a type of virus called HSV-2. Over the past 10 years, he has used various perspectives in the study of the problems associated with HSV and has contributed to each of the following areas: clinical, epidemiological, virological, cellular, and immunological, as well as to comparative and evolutionary aspects of herpetic infections in man and animals.

Among Dr. Nahmias' contributions are the finding that HSV-2 infection is a venereal disease, second only to gonorrhea in frequency; and the discovery of the strong possibility that HSV-2 is a causal agent in cancer of the cervix. Over the past eight years, since Dr. Nahmias and his Emory colleagues, including Zuher M. Naib, M.D., professor of pathology; William E. Josey, M.D., associate professor of gynecology-obstetrics; and others originated their genital herpes-cervical cancer hypotheses, HSV-2 has become one of the most likely suspects as a cause of several types of human cancers. Many believe that the work of Dr. Nahmias and his colleagues linking human cancer with viral infection may prove a major breakthrough in the road to new cancer preventive measures, and possibly a cancer vaccine.

Egyptian-born Dr. Nahmias is a professor of pediatrics, associate professor of preventive medicine, and chief, Infectious Disease and Immunology Section of the Department of Pediatrics at the Emory School of Medicine in Atlanta. He received the M.D. from George Washington University School of Medicine, Washington, D.C., in 1957 after earning his M.A. in bacteriology from the University of Texas, Austin, and the M.P.H. from the University of Michigan School of Public Health. He took his pediatric residency at Boston City Hospital. Dr. Nahmias came to Emory in 1964.

a trustee for the Medical Association of Atlanta.

Dr. Jones was a member of the Board of Directors for Fulton National Bank, a member of the Piedmont Driving Club and a founder and past commodore of the University Yacht Club.

Survivors include his widow, Frances Bird Jones; one daughter, Mrs. Ashley Walker; three sons, Charles Jones, Pope Jones and Dr. William Jones.

Lewell S. King

College Park surgeon Lewell S. King, 67, died August 18. Dr. King was a member of the American College of Surgeons and a diplomate of the American Board of Surgery. He has served as chief of staff of South Fulton Hospital and was on the staffs of Georgia Baptist and Crawford W. Long hospitals.

A graduate of Baylor University School of Medicine, Dr. King completed his internship and residency at Georgia Baptist Hospital with additional training at New York, Harvard University and the British postgraduate medical schools.

During World War II, Dr. King served as a lieutenant colonel in the Army Medical Corps. He was past president of the College Park Kiwanis Club, past master of the Masonic Lodge in Phillippi, W. Va. and a member of the director's staff of the Yaarab Shrine Temple.

Survivors include his widow, Mrs. Loraine Hartley King; son, Maj. Donald King of Atlanta.

Robert Grier Stephens

Washington family physician Robert Grier Stephens, 93, died at his home August 28. The Crawfordville native had practiced 30 years in Atlanta and 30 years in Wilkes County, and at his retirement when 89 was the oldest active practitioner in the state. In 1965 he was named General Practitioner of the Year.

Dr. Stephens was the great-nephew of Alexander H. Stephens, vice president of the Confederacy and a Georgia governor.

DR. HURST SELECTED FOR GOLD HEART AWARD

J. Willis Hurst, M.D., professor and chairman of the Department of Medicine at Emory University, has been selected to receive the 1974 Gold Heart Award of the American Heart Association, its highest honor for volunteer service. The award will be presented on November 21 during AHA's annual dinner in Dallas, Texas.

Dr. Hurst, an internationally-known cardiologist, was president of AHA in 1971-72 and a member of its board of directors from 1965 through 1973. He was president of Georgia Heart Association in 1963-64. Dr. Hurst has served on a number of national commissions advising the federal government on programs dealing with heart and blood vessel diseases.

The citation from American Heart describes Dr. Hurst is a "gifted teacher, able administrator, scientific investigator, physician and public policy consultant."



Robert G. Ellison (L) of Augusta, new president of the Georgia Heart Association, receives the gavel of office from outgoing President Charles R. Hatcher, Jr. of Atlanta during the 26th Annual Meeting and Scientific Sessions of the Association in Atlanta in September. C. Dan Cabaniss of Columbus was chosen president-elect and Joseph A. Wilber of Atlanta is the new vice president.

Dr. Stephens' son, Robert Grier Stephens, Jr., serves as a congressman from the 10th district.

Dr. Stephens was graduated from the University of Georgia and Atlanta College of Physicians and Surgeons, now Emory. He was an elder in Druid Hill Presbyterian Church and Washington Presbyterian Church. president of the Mary Willis Memorial Library, and a member of Kappa Alpha social fraternity.

Survivors include three daughters, Mrs. Dudley W. Reynolds of Atlanta, Mrs. Lucian C. Wilson of Washington and Mrs. J. Mason Williams of Perry, Fla.; son. Congressman Robert G. Stephens, Jr. of Athens.

Edward Stephens Wright

Edward Stephens Wright, 72, of Atlanta died September 6. He was a member of the Southern Medical Association, the American College of Surgeons and the American Academy of Ophthalmology and Otolaryngology.

As a student at the University of Georgia, Dr. Wright was a member of Alpha Tau Omega fraternity. His medical degree came from Emory University School of Medicine, followed by internship at Grady Hospital and the New York Eye and Ear Infirmary. Additional training came from the Chevalier Jackson Clinic in Philadelphia and the American University in Vienna, Austria.

Dr. Wright was on the staffs of Piedmont, Egleston, Emory, Grady Memorial and Crawford W. Long hospitals and St. Joseph's Infirmary. He was a member of the Piedmont Driving Club, Capital City Club, Commerce Club, University Yacht Club and Alpha Kappa Kappa medical fraternity. During World War II he served as a commander in the U.S. Navy Medical Corps.

Survivors include his widow, the former Mary Dean; and a brother, Thomas Wright of Atlanta.

CONTINUING EDUCATION COURSES IN GEORGIA

As a service to MAG physicians who wish to maintain their competence and skill by participating in continuing medical education (CME) programs, the following list of courses in Georgia for 1974 and 1975 is published.

Most of the courses below are sponsored by organizations, such as the Center for Disease Control and the Medical College of Georgia, which are accredited for CME by the AMA's Council on Medical Education. The listings were taken from the Supplement to *The Journal of the American Medical Association,* Volume 229, Number 7, which lists similar programs for 44 states and the District of Columbia.

In addition, the Medical Association of Georgia is now one of 28 state associations which have programs for accreditation of institutions sponsoring locally-oriented CME programs. Institutions accredited by MAG whose programs are described or listed below include the Atlanta Graduate Medical Assembly, Atlanta Society of Pathologists, Emory University, The Medical Center of Columbus and Piedmont Hospital in Atlanta.

Using the List

The courses are listed in chronological order and most references contain, in the following general order: the title of the course; name and address of the sponsoring organization; location; dates; number of hours of instruction; fee, if any; and the methods of instruction used. Space considerations have prompted the use of the following abbreviations for these methods of instruction:

Methods:

AV—Audiovisual aids
Clin C—Clinical Conference
Lab—Laboratory work
Lec—Lecture
O—Open question periods
OP—Enrollee observes procedure
Pan—Panel discussion
PI—Programmed instruction
PP—Enrollee performs procedure
Sem—Seminar
TV—Television

CME programs for the Atlanta Society of Pathologists, the Medical Center of Columbus and Piedmont Hospital continue throughout the year and a paragraph format is being used to describe them.

THE ATLANTA SOCIETY OF PATHOLOGISTS has been offering continuing education programs since 1955. Objectives of the society's CME work are to provide in-depth programs on specific topics, to exchange day to day laboratory ideas and to assist in the education of interested residents, medical students and medical technologists. Meetings are held the first Wednesday of each month, except usually in July and August when no meeting is held, and include lecture/panel format programs presented by members. Slides and other audiovisual methods are used and slide sets are available on each program. No fee is charged. An annual spring session is held in a hotel meeting room with a faculty of out of town speakers. Current president is Ayten Someren, M.D., Grady Memorial Hospital, 80 Butler St., S.E., Atlanta, Ga. 30303.

THE MEDICAL CENTER of Columbus holds in-house continuing medical education programs through the week in its auditorium. Medical Grand Rounds are held every Tuesday (except for the third Tuesday of each month from October through May), from 8:30 a.m. to 9:30 a.m. Day with Emory occupies the third Tuesday time slot October through May, from 8:30 to 9:30 a.m. and 12 noon to 1 p.m. Pediatric Grand Rounds are held every Thursday, 8:30 to 9:30 a.m.; Surgery Grand Rounds Fridays from 12:30 to 1:30 p.m. and Ob-Gyn Grand Rounds each Tuesday from 5:30 to 6:30 p.m.

The Medical Center's Departments of Ob-Gyn and Pediatrics sponsor the March of Dimes Genetic Counseling of Columbus program throughout the year. Participants meet from 8:15 a.m. to 12 noon the third Saturday of each month in the Auditorium and Family Practice Building of The Medical Center. Methods used include audiovisual, clinical conferences, lectures, live clinics, open question periods, patient demonstration, seminar, television and visiting consultants. For additional information, write C. Dan Cabaniss, M.D., the Medical Center, Columbus, Ga. 31901.

PIEDMONT HOSPITAL is a 300-bed facility on Peachtree Street in Northwest Atlanta serving physicians with weekly conferences which continue all year with the exception of holidays. No fee is charged for the conferences which are open to all physicians. Each begins at 8 a.m., and the weekly schedule includes: Monday—basic cardiology; Tuesday—endocrinology; Wednesday—internal medicine; Thursday—pulmonary; Friday—cardiology. Methods used are audiovisual materials, clinical conferences, lectures, panels, patient demonstration, programmed instruction and television. Contact Mark E. Silverman, M.D., Emory-Piedmont Professor of Medicine, 1968 Peachtree Road, N.W., Atlanta, Ga. 30309.

OCTOBER

BASIC LAB METHODS IN THE DETECTION OF HEMOGLOBINOPATHIES
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
4 days, 10/15/74 to 10/18/74 and 3/3/75 to 3/6/75; 28 hours of instruction; no fee
Methods: AV, Lab, Lec, O, OP, PP

ADMINISTRATION AND EDUCATION IN THE CLINICAL LAB
Medical College of Georgia
School of Medicine, Augusta 30902
2 days, 10/18/74 to 10/19/74; 13 hours of instruction
Methods: AV, Lec, O, Pan, Sem

LAB SCREENING FOR DRUGS OF ABUSE
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333

5 days, 10/21/74 to 10/25/74; 35 hours of instruction
Fee: $130
Methods: AV, Lab, Lec, O, OP, PP

IMMUNOFLUORESCENT DETECTION OF AUTOIMMUNE DISEASE
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
5 days, 10/21/74 to 10/25/74; 35 hours of instruction
Fee: $130
Methods: AV, Lab, Lec, O, OP, PP

PHYSICIANS CONTINUING EDUCATION SERIES
Laurens County Medical Society and VA Center, Dublin
Co-sponsor: Medical College of Ga., School of Medicine
VA Center and Brown's Restaurant, Dublin
1 day/month for 5 months, 10/22/74, 11/26/74, 1/28/75, 2/25/75, 3/25/75; 17½ hours instruction
Fee: $25/day; $100 series
Methods: AV, Lec, O

LAB METHODS IN ANAEROBIC BACTERIOLOGY
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta, 30333
10 days, 10/28/74 to 11/8/74 and 6/16/75 to 6/27/75; 70 hours of instruction
Fee: $260
Methods: AV, Lab, Lec, O, OP, PP

GAS LIQUID CHROMATOGRAPHY
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
4 days, 10/29/74 to 11/1/74; 28 hours of instruction
Fee: $104
Methods: AV, Lab, Lec, O, OP, PP

NOVEMBER

BASIC LAB METHODS IN VIROLOGY
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta, 30333
10 days, 11/4/74 to 11/15/74; 70 hours of instruction
Fee: $260
Methods: AV, Lab, Lec, O, OP, PP

RADIOLOGY OF THE NEWBORN AND INFANT
Emory University School of Medicine
69 Butler St., S.E., Atlanta, Ga. 30303
At Grady Memorial Hospital Auditorium
2 days, 11/8/74 and 11/9/74
Fee: residents, fellows and military personnel—$30; all others—$90
Methods: AV, Lec, O, Pan

CURRENT TRENDS IN CHILD PSYCHIATRY
U.S. Army Medical Center, Fort Gordon 30905
3 days, 11/11/74 to 11/13/74; 21 hours instruction
Methods: AV, Clin C, Lec, Pan, Sem

HUMAN BLOOD CELL MORPHOLOGY
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta, 30333
5 days, 11/11/74 to 11/15/74; 35 hours of instruction
Fee: $130
Methods: AV, Lab, Lec, O, OP, PP

CLINICAL MICROBIOLOGY IN CONTROL OF NOSOCOMIAL INFECTIONS
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, Atlanta 30333
5 days, 11/11/74 to 11/15/74 and 6/2/75 to 6/6/75; 35 hours instruction
Fee: $130
Methods: AV, Lab, Lec, O, OP, PP

GENERAL PEDIATRICS
American Academy of Pediatrics
Regency Hyatt House, Atlanta
3 days, 11/17/74 to 11/18/74; 24 hours of instruction
Fee: $75 members; $105 non-members and reg. fee
Methods: AV, Lec, O, Sem

PRINCIPLES AND BACTERIAL APPLICATION OF FLUORESCENT ANTIBODY TECHNIQUES
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
10 days, 11/25/74 to 12/6/74; 70 hours instruction
Fee: $260
Methods: AV, Lab, Lec, O, OP, PP

DECEMBER

POSTGRADUATE CONFERENCE ON GYNECOLOGY AND OBSTETRICS
Emory University School of Medicine
69 Butler St., S.E., Atlanta, Ga. 30303
At Grady Memorial Hospital Auditorium
3 days, 12/2/74 to 12/4/74
Fee: $100
Methods: AV, Lec, O, Pan

SERODIAGNOSIS OF TOXOPLASMOSIS, RUBELLA, CYTOMEGALIC INCLUSION DISEASE AND HERPES SIMPLEX
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
5 days, 12/2/74 to 12/6/74; 35 hours of instruction
Fee: $130
Methods: AV, Lab, Lec, O, OP, PP

TUBERCULOSIS TODAY!
Center for Disease Control, TB Control Division, USPHS
1600 Clifton Road, N.E., Atlanta 30333
5 days, 12/9/74 to 12/12/74; 32 hours of instruction (offered 3 additional times between 1/1/74 and 8/31/75)
Fee: $125
Methods: AV, Clin C, O, OP, PI, PP, Sem

CONTINUOUS FLOW ANALYSIS
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, Atlanta 30333
3 days, 12/10/74 to 12/12/74; 21 hours of instruction
Fee: $78
Methods: AV, Lab, Lec, O, OP, PP

JANUARY

LAB METHODS IN MEDICAL MYCOBACTERIOLOGY
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
10 days, 1/6/75 to 1/17/75; 70 hours of instruction
Fee: $260
Methods: AV, Lab, Lec, O, OP, PP

LAB DIAGNOSIS BY SEROLOGIC METHODS
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
10 days, 1/6/75 to 1/17/75; 70 hours of instruction
Fee: $260
Methods: AV, Lab, Lec, O, OP, PP

PHYSICIANS CONTINUING EDUCATION SERIES
Whitfield County Medical Society, Dalton
Co-sponsor: Medical College of Georgia, School of Medicine
Held at Hamilton Memorial Hospital, Dalton
1 day/month for 4 months, 1/9/75, 2/13/75, 3/13/75, 4/3/75; 16 hours of instruction
Methods: AV, Lec, O, Pan, Sem

DETECTION OF SALMONELLA IN FOODS AND FEEDS BY FLUORESCENT ANTIBODY AND CULTURAL METHODS
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333

10 days, 1/20/75 to 1/31/75; 70 hours of instruction
Fee: $260
Methods: AV, Lab, Lec, O, OP, PP

LAB DIAGNOSIS OF VIRAL DISEASES
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
10 days, 1/27/75 to 2/7/75; 70 hours of instruction
Fee: $260
Methods: AV, Lab, Lec, O, OP, PP

FEBRUARY

LAB METHODS IN SYSTEMIC MYCOSES
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
10 days, 2/3/75 to 2/14/75; 70 hours of instruction
Fee: $260
Methods: AV, Lab, Lec, O, OP, PP

KINETIC ASSAY OF ENZYMES
Center for Disease Control, Bureal of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
2 days, 10/3/74 to 10/4/74 and 2/13/75 to 2/14/75; 14 hours of instruction
Fee: $52
Methods: AV, Lab, Lec, O, OP, PP

ACOG DISTRICT IV ANNUAL CONTINUING EDUCATION CONFERENCE
Fairmont Colony Square Hotel, Atlanta
2½ days, 2/16/75 to 2/19/75; 16 hours of instruction
Fee: none
Methods: Lec, O, Pan, Sem

LAB METHODS IN GENERAL MEDICAL BACTERIOLOGY
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
10 days, 2/17/75 to 2/28/75; 70 hours of instruction
Fee: $260
Methods: AV, Lab, Lec, O, OP, PP

BASIC NEUROLOGY FOR THE PRACTITIONER
Medical College of Georgia, School of Medicine, Augusta 30902
2 days, 2/20/75 to 2/21/75; 13 hours of instruction
Methods: AV, Lec, O, Pan, Sem, TV

CLINICAL PSYCHIATRY
Medical College of Georgia, School of Medicine, Augusta 30902
2 days, 2/27/75 to 2/28/75; 13 hours of instruction
Methods: AV, Lec, O, Pan, Sem, TV

PULMONARY SYMPOSIUM II, THE PRACTICAL USE OF RESPIRATORY CARE
West Georgia Chapter, Georgia Lung Association and the Georgia Society for Respiratory Therapy
Holiday Inn of Callaway Gardens, Pine Mountain
2 days, 2/27/75 to 2/28/75; 6 hours of instruction
Fee: $30
Methods: AV, Lab, Lec, P, Pan, Sem

MARCH

QUALITATION AND QUANTITATION OF IMMUNOGLOBULINS
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
5 days, 3/3/75 to 3/7/75; 35 hours of instruction
Fee: $130
Methods: AV, Lab, Lec, O, OP, PP

MEDICINE AND RELIGION
Medical College of Georgia, School of Medicine, Augusta 30902
1 day, 3/10/75; 6½ hours of instruction
Methods: AV, Lec, O, Pan, Sem

ATLANTA GRADUATE MEDICAL ASSEMBLY
Fairmont Colony Square, Atlanta
3 days, 3/10/75 to 3/12/75; approximately 35 hours of instruction
Fee: $15 (MAA members), $75 (visiting M.D.'s)
Methods: AV, Lec, O, Pan, Sem, TV

MICROBIOLOGY OF THE HOSPITAL ENVIRONMENT
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
4 days, 3/11/75 to 3/14/75
28 hours of instruction. Fee: $104

MAKING SURGICAL DECISIONS
Medical College of Georgia, School of Medicine, Augusta 30902
2 days, 3/13/75 to 3/14/75; 13 hours instruction
Methods: AV, Lec, O, Pan, Sem, TV

LAB METHODS IN ENTERIC BACTERIOLOGY
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta, 30333
10 days, 3/17/75 to 3/28/75; 70 hours of instruction
Fee: $260
Methods: AV, Lab, Lec, O, OP, PP

THIRD ANNUAL PERINATAL MEDICINE CONFERENCE
Department of Ob-Gyn and Pediatrics of The Medical Center, Columbus; co-sponsored by the Family Practice Department
Holiday Inn of Callaway Gardens, Pine Mountain
2 days, 3/20/75 to 3/21/75
Fee: not yet determined
Methods: AV, Lec, O, Pan, Sem

GASTROINTESTINAL DISEASES
Medical College of Georgia, School of Medicine, Augusta 30902
Held at Atlanta Marriott Motor Hotel, Atlanta
3 days, 3/20/75 to 3/22/75; 17 hours of instruction
Methods: AV, Lec, O, Pan, Sem

LAB METHODS IN DERMATOLOGIC MYCOLOGY
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
10 days, 3/31/75 to 4/11/75; 70 hours of instruction
Fee: $260
Methods: AV, Lab, Lec, O, OP, PP

APRIL

INFECTIOUS DISEASES—DIAGNOSIS AND MANAGEMENT
Medical College of Georgia, School of Medicine, Augusta 30902
2 days, 4/3/75 to 4/4/75; 13 hours of instruction
Methods: AV, Lec, O, Pan, Sem

PEDIATRIC CARDIOLOGY
Emory University School of Medicine
69 Butler St., S.E., Atlanta, Ga. 30303
At Grady Memorial Hospital Auditorium
2 days, 4/7/75 and 4/8/75
Fee: $100
Methods: AV, Lec, O, Pan

LAB METHODS IN MEDICAL PARASITOLOGY, PART 1: INTESTINAL PARASITES
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333

20 days, 4/7/75 to 5/2/75; 140 hours of instruction
Fee: $520
Methods: AV, Lab, Lec, O, OP, PP

CARDIOLOGY FOR THE FAMILY PHYSICIAN
Emory University School of Medicine
69 Butler St., S.E., Atlanta, Ga. 30303
At Royal Coach Motor Hotel, Atlanta
4 days, 4/9/75 to 4/12/75
Fee: $100
Methods: AV, Lec, O, Pan

SOUTHEASTERN, AMERICAN UROLOGICAL ASSOCIATION
Marriott Motor Hotel, Atlanta
5 days, 4/13/75 to 4/17/75; 35 hours of instruction
Methods: AV, Lec, Pan, TV

GYNECOLOGIC ONCOLOGY
Emory University School of Medicine
69 Butler St., S.E., Atlanta, Ga. 30303
At Crawford W. Long Hospital, Atlanta
3 days, 4/14/75 to 4/16/75
Fee: $300
Methods: AV, Lec, O, Pan

RADIOIMMUNOASSAY AND OTHER LAB METHODS FOR HEPATITIS-B ANTIGEN DETECTION
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
3 days, 4/14/75 to 4/16/75; 21 hours of instruction
Fee: $78
Methods: AV, Lab, Lec, O, OP, PP

OBSTETRICS-GYNECOLOGY
American College of Surgeons, 1975 Spring Meeting, Atlanta
1½ days, 4/21/75 to 4/24/75; 9 hours of instruction
Fee: $40
Methods: AV, Lec, O, Pan, Sem

OPHTHALMIC SURGERY
American College of Surgeons, 1975 Spring Meeting, Atlanta
1½ days, 4/21/75 to 4/24/75; 9 hours of instruction
Fee: $40
Methods: AV, Lec, O, Pan, Sem

CANCER OF THE GASTROINTESTINAL TRACT
FLUID, ELECTROLYTE AND ACID-BASE BALANCE
GASTROINTESTINAL SURGERY
PERIPHERAL VASCULAR DISEASE
RESPIRATORY FAILURES IN SURGERY
American College of Surgeons, 1975 Spring Meeting, Atlanta
1½ days, 4/21/75 to 4/24/75; 9 hours of instruction
Fee: $40
Methods: AV, Lec, O, Pan, Sem

MAY

A POSTGRADUATE CONFERENCE ON HIGH RISK PREGNANCY
Emory University School of Medicine
69 Butler St., S.E., Atlanta, Ga. 30303
At Grady Memorial Hospital Auditorium
3 days in May 1975
Fee: no charge
Methods: AV, Lec, O, Pan

LAB METHODS IN MEDICAL PARASITOLOGY, PART 2: BLOOD PARASITES
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
10 days, 5/5/75 to 5/16/75; 70 hours instruction
Fee: $260
Methods: AV, Lab, Lec, O, OP, PP

CARDIOLOGY POSTGRADUATE COURSE
Emory University School of Medicine
69 Butler St., S.E., Atlanta, Ga. 30303
At Royal Coach Motor Hotel, Atlanta
4 days, 5/12/75 to 5/15/75
Fee: ?
Methods: AV, Lec, O, Pan

BASIC LAB TECHNIQUES IN CELL CULTURE
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
6 days, 5/16/75 to 5/23/75; 42 hours of instruction
Fee: $156
Methods: AV, Lab, Lec, O, OP, PP

HUMAN BLOOD CELL MORPHOLOGY—ADVANCED
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
5 days, 5/19/75 to 5/23/75; 35 hours of instruction
Fee: $130
Methods: AV, Lab, Lec, O, OP, PP

RECENT ADVANCES IN OPHTHALMOLOGY
Medical College of Georgia, School of Medicine, Augusta 30902
Held at the Cloister, Sea Island
3 days, 5/19/75 to 5/21/75; 14 hours of instruction
Methods: AV, Lec, O, Pan, Sem

JUNE

INTERNAL MEDICINE
Medical College of Georgia, School of Medicine, Augusta
Held at Buccaneer Motor Lodge, Jekyll Island State Park, Jekyll Island
3 days, 6/12/75 to 6/14/75; 12 hours of instruction
Methods: AV, Lec, O, Pan, Sem

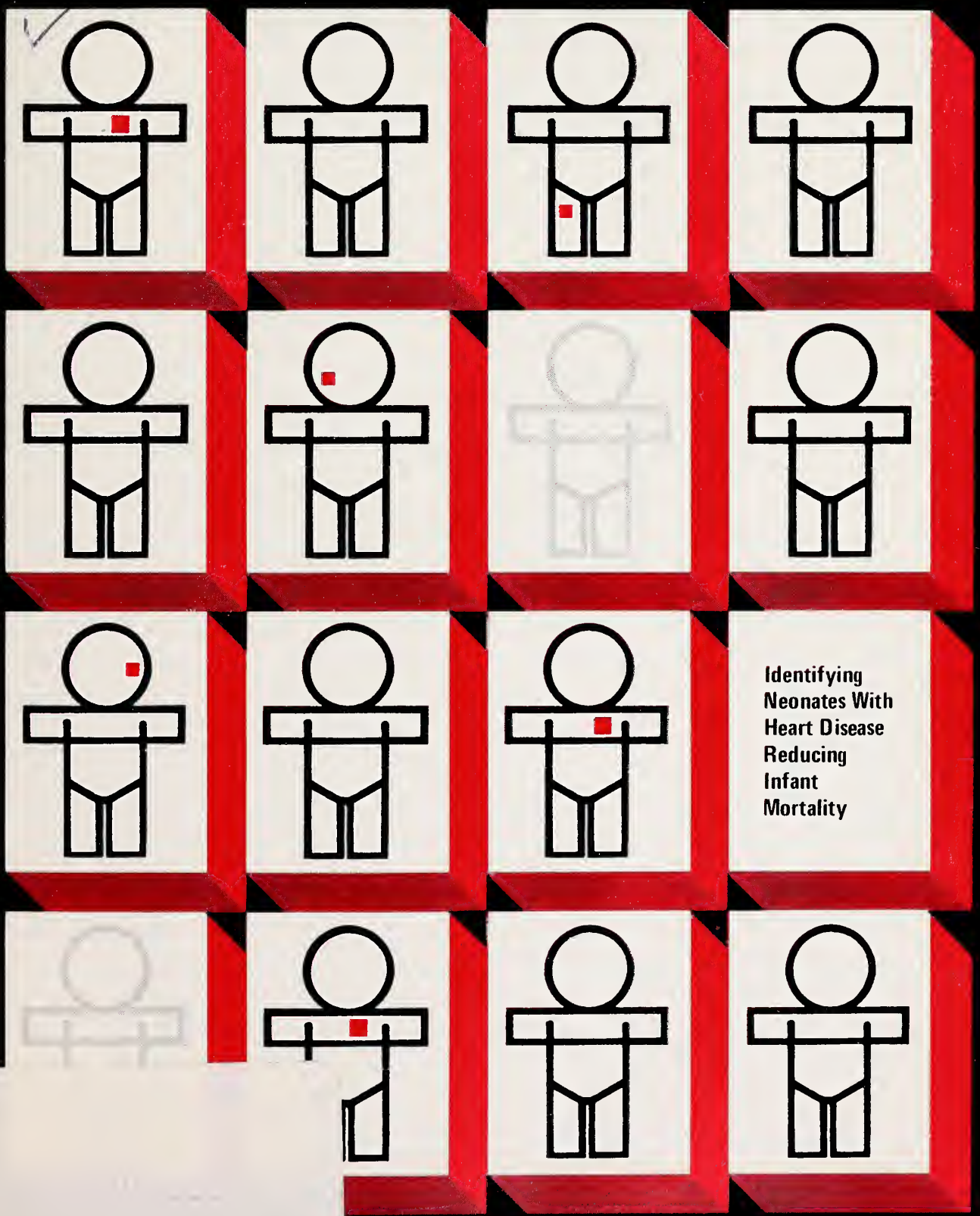
JULY

LAB METHODS IN GENERAL MEDICAL MYCOLOGY
Center for Disease Control, Bureau of Labs, USPHS
1600 Clifton Road, N.E., Atlanta 30333
20 days, 7/75 to 8/75; 140 hours of instruction
Fee: $520
Methods: AV, Lab, Lec, O, OP, PP

SEPTEMBER

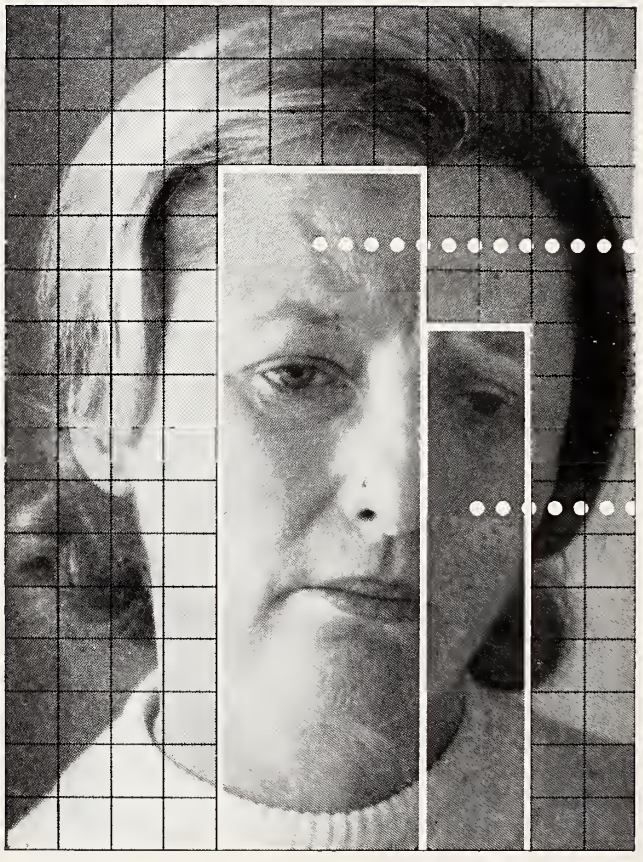
PROBLEM-ORIENTED RECORD POSTGRADUATE COURSE
Emory University School of Medicine
69 Butler St., S.E., Atlanta, Ga. 30303
At Royal Coach Motor Hotel, Atlanta
4 days, 9/8/75 to 9/11/75
Fee: ?
Methods: AV, Lec, O, Pan

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Identifying Neonates With Heart Disease Reducing Infant Mortality

Both often



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequen and/or severity of grand mal seizures m require increased dosage of standard an convulsant medication; abrupt withdraw may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous in gestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) hav occurred following abrupt discontinuanc (convulsions, tremor, abdominal and mu cle cramps, vomiting and sweating). Kee addiction-prone individuals under carefu

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Factors in the Reduction of Infant Mortality in a Maternity and Infant Care Project

EDWIN S. BRONSTEIN, M.D., M.P.H., *Augusta**

THE MATERNITY AND INFANT CARE Project in Augusta was the sixth such project in the United States; it began in 1965 as a joint effort of the Medical College of Georgia and the Richmond County Health Department to provide services to a high risk population in 11 Georgia counties. The project serves both an urban and a rural population. In 1964, there were 127,400 people residing in the 10 rural counties, and 130,000 in the urban county. The nonwhite infant mortality in the 10 rural counties was 62.7 per 1,000 live births; the neonatal mortality was 30.4 per thousand live births; the perinatal mortality rate was 59.5 per thousand births; and the premature rate was 152.0 per thousand live births. Forty-five per cent of nonwhite women were delivered by granny midwives. A lack of physician manpower, inadequate health care facilities and a high percentage of poverty were also characteristics of this population.

The impact of an Augusta project in a rural and urban high risk community is demonstrated.

Udry et al.,[1] attribute the decline in infant mortality in the United States from 1960 to 1968 to "family planning." Udry feels the shift in age, birth-order distribution has affected the infant mortality and concludes that Maternity and Infant Care Projects have contributed to less than one seventh of the reduction in infant mortality.

An improvement in infant mortality in the Augusta project should be attributed to the coordinated program of maternal and infant care and family planning, rather than to either one alone. By examination of the vital statistics of the project area and the factors related to the reduction in infant mortality, a stronger case is made for a comprehensive program which provides both maternal and infant care as well as family planning. The demonstrated shift in age, birth-order distribution; namely a significant reduction in births to high risk women in the project area compared to a control area supports the impact of the Maternity and Infant Care Project on its target area. There are 11 counties in the Augusta project; 10 are rural and one is urban; this paper will deal with both groups.

Selecting Statistics

The factors in selecting the vital statistics as a measure of the impact of this project on its target population were the following:

1. Most rural blacks in the 10 rural counties are poor and are now being delivered in hospitals rather than by granny midwives;
2. Eighty-five per cent of patients cared for on the Eugene Talmadge Memorial Hospital obstetric service are black;
3. Many rural counties have no physicians to provide obstetrical care;
4. Fifty-nine per cent of all the blacks having live births in the 10 rural counties are delivered at the Eugene Talmadge Memorial Hospital, while most urban clinic patients from Richmond County (the eleventh county) are delivered at the University Hospital.
5. Sixty-seven per cent of all patients who deliver

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at the Eugene Talmadge Memorial Hospital reside in the 10 rural counties.

The vital statistics from the 10 rural project counties (experimental group) and all eleven project counties were compared to the vital statistics from a control population, Georgia less the 11 project counties of Augusta and the five counties of Atlanta (Georgia–11C–5C), the site of the other Maternity and Infant Care Project in Georgia.

The infant mortality rates[2] by race in the years 1964 and 1970 and the percentage of rate change have been compared for the experimental group (Augusta project) and the control group (Georgia–11C–5C). Special attention is given to the nonwhite rural group because this group is predominately poor and, as such, make up the largest percentage of high risk patients in the target area. The year 1964 was selected because it was the last year prior to the inception of the Augusta project and 1970, because it was the last year before the advent of an extensive family planning program in the project area.

The age and birth order distribution of women who delivered in 1964 and 1970 was also examined and the per cent of change among high risk women was compared for the experimental and the control areas.[3] High risk was defined as all women less than 17 years of age having their first pregnancy; women less than 19 years having more than their first pregnancy; women having more than their fifth pregnancy and all women over 40 years having any number of pregnancies. To determine rates, age-specific census interpolation data was used.[4]

Results

Infant Mortality (see Table 1)

Defined as the number of infant deaths per 1000 live births.

1. *Ten rural project counties:* In 1964 the infant death rate was 51.4 per thousand. In 1970 the rate decreased 44.9 per cent to 28.3 per thousand. In 1964, the nonwhite infant death rate was 62.7 per thousand. In 1970, the rate decreased 36.4 per cent to 39.9 per thousand.

2. *Eleven project counties:* In 1964, the infant death rate was 38.8 per thousand. By 1970, the infant death rate decreased 41.2 per cent to 22.8 per thousand. In 1964, the nonwhite infant death rate was 51 per thousand. By 1970, the nonwhite infant death rate decreased 39.0 per cent to 31.1 per thousand.

3. *Georgia–11C–5C:* In 1964, the infant death rate was 29.9 per thousand. By 1970, the infant death rate decreased 20.1 per cent to 23.9 per thousand. In 1964, the nonwhite infant death rate was 43.8 per thousand. By 1970, the nonwhite infant death rate decreased 15.5 per cent to 37.0 per thousand.

Births to High Risk Women (see Table 2)

1. *Ten rural project counties:* In 1964, the rate of age-specific births to high risk women was 50.6 per thousand. In 1970, the rate decreased 44.1 per cent to 28.3 per thousand. In 1964, the nonwhite rate of age-specific births to high risk women was 92.0 per thousand. In 1970, the rate decreased 48.5 per cent to 47.3 per thousand.

2. *Eleven project counties:* In 1964, the rate of age-specific births to high risk women was 37.9 per thousand. In 1970, the rate decreased 45.3 per cent to 20.7 per thousand. In 1964, the nonwhite rate of age-specific births to high risk women was 72.5 per thousand. By 1970, the nonwhite rate decreased 47.4 per cent to 38.2 per thousand.

3. *Georgia–11C–5C:* In 1964, the rate of age-specific births to high risk women was 33.6 per thousand. In 1970, the rate decreased 45.5 per cent to

TABLE 1

INFANT DEATHS

NUMBER, RATE AND PERCENT CHANGE BY RACE FROM 1964 TO 1970

	1964			1970			Percent Change 1964-1970		
	T	W	N-W	T	W	N-W	T	W	N-W
10C MIC									
Number	162	32	130	74	18	56	–54.3	–43.8	–56.9
Rate	51.4	29.7	62.7	28.3	14.9	39.9	–44.9	–49.8	–36.4
11C MIC									
Number	253	88	165	135	55	80	–46.6	–37.5	–51.5
Rate	38.8	26.9	51.0	22.8	16.5	31.1	–41.2	–38.7	–39.0
Ga.–11C–5C									
Number	2,024	950	1,047	1,466	756	710	–27.6	–20.4	–33.9
Rate	29.9	22.0	43.8	23.9	17.9	37.0	–20.1	–18.6	–15.5

Source: Vital and Morbidity Statistics, Georgia, 1964, 1970.

TABLE 2

BIRTHS TO HIGH RISK WOMEN

NUMBER, RATE AND PERCENT CHANGE BY RACE FROM 1964 TO 1970

	1964			1970			Percent Change 1964-1970		
	T	W	N-W	T	W	N-W	T	W	N-W
10C MIC									
Number	1,180	189	991	705	183	522			
Rate	50.6	15.8	92.0	28.3	13.3	47.3	–44.1	–16.0	–48.5
11C MIC									
Number	2,038	563	1,475	1,237	411	826			
Rate	37.9	17.2	72.5	20.7	10.9	38.2	–45.3	–54.0	–47.4
Ga.–11C–5C									
Number	19,495	7,769	11,726	11,232	4,793	6,439			
Rate	33.6	18.3	74.6	18.3	10.5	40.8	–45.5	–42.7	–45.3

Source: Vital and Morbidity Statistics, Georgia, 1964, 1970.

18.3 per thousand. In 1964, the nonwhite rate of age-specific births to high risk women was 74.6 per thousand. By 1970, the rate decreased 45.3 per cent to 40.8 per thousand.

Discussion

The high risk target area of the Maternity and Infant Care Project in 1964 had a high rate of nonwhite infant mortality (62.7 per thousand) in the 10 rural counties. In the same year, in Georgia–11C–5C, the rate was 43.8 per thousand. By 1970, significant reductions in the nonwhite rate of 36.4 per cent had occurred in the 10 counties and 39.0 per cent in the 11 counties, while only a 15.5 per cent decrease was noted in Georgia–11C–5C. In 1964, 54 per cent of the 10-county population was nonwhite and in 1970, 46 per cent was nonwhite.

Several factors can be associated with infant mortality reduction. The first factor is a reduction in the neonatal death rate which may be a measure of the quality of obstetrical and pediatric care. In the 10 rural counties, the decrease in nonwhite neonatal mortality was significantly greater (46.1 per cent) than the control group, Georgia–11C–5C (10.1 per cent) (Table 3).

Reduction in prematurity rates is a second factor in reducing infant mortality. In the project area, significant reductions were noted. A decrease of 14.8 per cent in the 10-county, nonwhite premature birth rate and 13.8 per cent in the 11 counties, compared to an increase of 3.9 per cent in Georgia–11C–5C. Among the 10-county nonwhites there were 133 fewer premature births, a 42.2 per cent decrease from 1964 to 1970 compared to a decrease in Georgia–11C–5C of 18.6 per cent. In 1964, 315 of the 404 prematures (77.9 per cent) were nonwhite in the 10 counties. There were 133 fewer 10-county premature nonwhite births in 1970, while only two less premature white births. The major premature birth reduction was among the nonwhite population and suggests that Eugene Talmadge Memorial Hospital and the Maternity and Infant Care Project have had an impact on the target population (Table 4).

Perinatal mortality, a measure of the quality of

TABLE 3

NUMBER, RATE AND PERCENT CHANGE BY RACE FROM 1964 TO 1970
NEONATAL DEATHS

	1964			1970			Percent Change 1964-1970		
	T	W	N-W	T	W	N-W	T	W	N-W
10C MIC									
Number	89	26	63	39	16	23	–56.2	–38.5	–63.5
Rate	28.3	24.1	30.4	14.9	13.2	16.4	–47.3	–45.2	–46.1
11C MIC									
Number	160	73	87	84	45	39	–47.5	–38.4	–55.2
Rate	24.5	22.3	26.8	14.2	13.5	15.1	–42.0	–39.9	–43.7
Ga.–11C–5C									
Number	1246	690	556	984	592	392	–21.0	–14.2	–29.5
Rate	18.4	16.0	22.7	16.0	14.1	20.4	–13.0	–11.9	–10.1

Source: Vital and Morbidity Statistics, Georgia, 1964, 1970.

obstetric and pediatric care in a community and a third factor in infant mortality reduction has also been significantly affected by the Maternity and Infant Care Project. A decrease of 35.6 per cent in the 10-county, nonwhite perinatal mortality rate and 29.8 per cent in the 11 counties, compared to a 17.5 per cent decrease in Georgia–11C–5C (Table 5).

Although the objectives of the Maternity and Infant Care Projects were to reduce infant mortality and prematurity through quality care, the change of these vital statistics alone cannot be an adequate measure of the benefits of such programs in different areas of the country. The Augusta project has provided many services to improve the social, physical and mental well-being of patients, through access, continuity and coordination of maternity and infant health care. The effect of these factors is hard to measure statistically. Project funds provide transportation for patients from areas up to within 100 miles of Augusta. A system of reliable chauffeurs make regular trips to take four or five patients to Augusta for prenatal care and for delivery. In some counties, project clinicians provide antenatal and infant care to patients in the local health department clinics.

At the Eugene Talmadge Memorial Hospital and Clinic, antenatal care, delivery, postpartum, interconceptional and infant care through the first year of life are provided for project patients. Urban patients are provided care at the University Hospital in Augusta by project staff. The patient and her family are often provided social and nursing services which aim to reduce those barriers which prevent patients from receiving quality care. All patients residing in the 11 counties requiring antenatal care are considered project patients and receive the care of a multidiscipline team consisting of an obstetrician, pediatrician, public health nurse, nutritionist and social worker. Coordination with rural health department nurses provides a constant exchange of information and services. Services include family planning, social services, nutrition advice, intensive care of the newborn and rural maternal and infant care services. Coordination between the Richmond Coun-

TABLE 4

PREMATURE BIRTHS
NUMBER, RATE AND PERCENT CHANGE BY RACE FROM 1964 TO 1970

	1964			1970			Per Cent Change 1964-1970		
	T	W	N-W	T	W	N-W	T	W	N-W
10C MIC									
Number	404	89	315	269	87	182	−33.4	− 2.2	−42.2
Rate	128.3	82.6	152.0	102.9	72.0	129.5	−19.8	−12.8	−14.8
11C MIC									
Number	758	275	483	562	232	330	−25.9	−15.6	−31.7
Rate	116.2	84.0	148.6	95.0	69.5	128.1	−18.2	−17.3	−13.8
Ga.–11C–5C									
Number	6319	3080	3239	5679	3042	2637	−10.1	− 1.2	−18.6
Rate	93.3	71.4	132.0	92.6	72.2	137.2	−0.8	+ 1.1	+ 3.9

Source: Vital and Morbidity Statistics, Georgia, 1964, 1970.

TABLE 5

PERINATAL DEATHS
NUMBER, RATE AND PERCENT CHANGE BY RACE FROM 1964 TO 1970

	1964			1970			Percent Change 1964-1970		
	T	W	N-W	T	W	N-W	T	W	N-W
10C MIC									
Number	174	47	127	95	40	55	−45.4	−14.9	−56.7
Rate	53.8	42.8	59.5	35.6	32.5	38.3	−33.8	−24.1	−35.6
11C MIC									
Number	311	123	188	202	98	104	−35.1	−20.3	−44.7
Rate	46.6	37.0	56.1	33.5	28.9	39.4	−28.1	−21.9	−29.8
Ga.–11C–5C									
Number	2539	1297	1242	1905	1109	796	−25.0	−14.5	−35.9
Rate	37.0	30.0	49.2	30.6	26.0	40.6	−17.3	−13.3	−17.5

Source: Vital and Morbidity Statistics, Georgia, 1964, 1970.

ty Health Department, the Medical College of Georgia and the rural health departments is an important factor in the successful operation of this program.

The program has evolved into one of careful identification of high risk patients through history, physical examination, laboratory and social screening measures. High risk patients are monitored from early pregnancy through labor and delivery. Quality of care is monitored by case conferences and perinatal mortality and morbidity conferences regularly held by the Departments of Obstetrics and Gynecology and Pediatrics. The cost of inhospital care and drugs for high risk patients may be totally paid for by the project, thus relieving the patient of any concern about cost of care.

There are few doctors practicing obstetrics in these rural areas and the quality of all maternity and infant care appeared to be influenced by the Maternity and Infant Care Project. There was a decrease of 44.9 per cent in the total infant mortality in the 10 counties, 41.2 per cent in the 11 counties compared to 20.1 per cent among all patients in Georgia–11C–5C.

Udry[5] attributes less than one seventh of the reduction in infant mortality to Maternity and Infant Care Projects. It appears unlikely, from the data presented, that the reduction in infant mortality is the result of family planning to the exclusion of maternity and infant care. It appears more likely that improved care and increased infant survival may account for greater utilization of family planning services and for a decrease in the rate of births to high risk women.

A 48.5 per cent reduction in the rate of births to nonwhite high risk women in the project compared significantly to a reduction in the control area of 45.3 per cent. High risk women made up the greatest percentage of women having sterilizing operations at the Eugene Talmadge Memorial Hospital during 1964 and 1970.[6] The shift in the age, birth-order distribution as demonstrated by a reduction in the percentage of births to high risk women, is influenced by the quality of maternity and infant care services which lead to improved survival. Many patients receiving such care, who have had a reduction in pregnancy wastage, have elected sterilization. This method of family planning is coordinated with maternity services and has allowed many high risk patients to selectively prevent future child bearing. This may shift the age, birth-order distribution to lower risk patients; it is "family planning" coordinated with maternity and infant care.

Summary

In this high risk area of 10 rural counties and one urban county, significant reductions in infant mortality have been noted. Reductions were significantly greater than the changes in a control population which did not have a Maternal and Infant Care Project between the years 1964 and 1970. Some of the factors which affect the reduction in infant mortality are reductions in neonatal and perinatal mortality and prematurity rates; the reduced percentage of births to high risk women; the increased number of high risk women selecting sterilization; the improved access to health care through better transportation, payment for hospital services and drugs; the coordination of hospital services with local health departments; the use of a multidiscipline team and the provision of quality maternal and infant care and family planning services.

Acknowledgements

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Early Identification of Neonates With Heart Disease

P. SYAMASUNDAR RAO, M.B. *and* WILLIAM B. STRONG, M.D., *Augusta**

NEONATES WITH DISTRESS CAUSED by a cardiac malformation will die if not treated appropriately and rapidly. They must all be considered acute emergency problems. Untreated congenital heart disease (CHD) in the neonatal period carries considerable mortality. If we are to increase the survival rate in this age group, it is necessary that these infants be promptly recognized and treated. Table 1 indicates the steps essential to the management of the infants. Prompt identification and initial management of these infants is the responsibility of the primary physician caring for the newborn. Rapid and safe transportation of the infants with suspected serious heart disease to a Regional Pediatric Cardiology Center equipped with facilities for diagnosis and treatment is the next logical step. Accurate anatomic diagnosis and appropriate medical and/or surgical treatment is in the realm of the pediatric cardiologist and cardiovascular surgeon. Significant advances have occurred during the past few decades in the diagnostic and therapeutic aspects of neonatal heart disease. If these advances are to be used effectively, the newborn with heart disease must be promptly identified. In this report, we will outline the functional evaluation of the newborn that may be helpful in identification of neonates with heart disease.

TABLE 1

Prompt Identification
↓
Rapid Transportation To a Well-Equipped Center
↓
Correct Anatomic & Physiologic Diagnosis
↓
Appropriate and Immediate Medical and Surgical Treatment

FUNCTIONAL DIAGNOSIS OF CHD

Many articles have appeared during the past few years in which the diagnostic features of specific anatomic defects are detailed and these are unnecessary for the identification of the infant with CHD. Even the experienced pediatric cardiologist often cannot make an accurate anatomic diagnosis of the defect prior to cardiac catheterization. Therefore, attempts by the primary physician to make an anatomic diagnosis in a neonate will often cause unnecessary delay in referral and loss of precious time. Recent articles[4, 8] recommended that attempts be made by the primary physician for early identification of the neonate with CHD by using the functional approach.

The clinical presentation of the newborn infant with a cardiac defect is dependent upon the status of the fetal circulatory pathways (patent foramen ovale, ductus venosus and ductus arteriosus) and the pulmonary vascular bed. In addition, there is marked variation in the physical signs of a given cardiac defect in a neonate when compared to the older child. The clinical manifestations and laboratory data that are helpful in identifying functionally important heart disease will be outlined in this paper.

Cyanosis

Cyanosis is one of the most important and helpful findings in the detection of the neonate with CHD. Cyanosis may be central or peripheral. Acrocyanosis (peripheral cyanosis) is frequently seen in the newborn infant and is often a confusing factor. Peripheral cyanosis exhibits as blue or dusky discoloration of skin of hands and feet and may be due to peripheral vasoconstriction secondary to a cold environment and slow blood flow in these areas. If acrocya-

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nosis is suspected, the infant should be examined in a warm environment, when the peripheral cyanosis should disappear. Central cyanosis is a bluish discoloration not only of the extremities but also of the buccal and labial mucous membrances. Visible central cyanosis can be recognized only when 3 gms/100 ml or more of reduced hemoglobin is present in the arterial blood.[3] Despite significant desaturation, an infant with anemia may not show signs of cyanosis whereas an infant with polycythemia may appear cyanotic without any significant arterial desaturation.[3, 4, 7, 8] Fetal hemoglobin, acidosis, hypoxia and the enzyme, 2, 3-diphosphoglycerate (DPG) will influence the oxygen affinity of the hemoglobin and therefore effect the manifestations of cyanosis. Total hemoglobin level and the factors influencing its affinity for oxygen must be kept in mind when evaluating for cyanosis.

Central cyanosis can be caused by many and varied conditions, the two most common being pulmonary parenchymal disease (hyaline membrane disease and aspiration syndrome) and congenital heart disease with right-to-left shunting or with severe congestive heart failure. Other causes of neonatal cyanosis include central nervous system disease (which causes hypoventilation), mechanical interference with lung function (diaphragmatic hernia, pneumothorax), abnormal oxygen-hemoglobin affinity (methemoglobinemia), polycythemia (maternal or feto-fetal transfusion), hypoglycemia, sepsis and shock. Detailed discussion of differential diagnosis is beyond the scope of this paper. The most important differential diagnosis is the determination of cardiac versus pulmonary origin of the cyanosis. Other physical findings associated with cyanosis are sometimes helpful in determining the causative factors of cyanosis. The level of arterial PCO_2 and the response of the arterial PO_2 to 100 per cent oxygen breathing for 10-15 minutes have been used to make this distinction.[3] Infants with cardiac cyanosis show no significant increase in PO_2 (< 10 mmHg) with 100 per cent oxygen and the infants with non-cardiac cyanosis may raise their PO_2 significantly. These are not consistently reliable in all cases, however.

Respiratory Pattern

The respiratory rate in normal resting newborns is usually under 60/min. Respiratory distress may manifest as tachypnea, retractions, wheezing, rales or grunting. Tachypnea, i.e., increased respiratory rate with normal or reduced tidal volume is present in neonates with heart disease with elevated pulmonary venous pressure and in infants with large left-to-right shunts and increased pulmonary arterial pressures. Increased rate and depth (tidal volume) of respiration-hyperpnea is suggestive of hypoxia and is seen in infants with transposition of the great arteries. Expiratory wheeze, grunting and retractions are commonly observed with pulmonary parenchymal disease and are associated with airway obstruction and/or decreased lung compliance. Grunting is classically seen in hyaline membrane disease. Inspiratory stridor is obviously a sign of upper airway obstruction. Finally, periodic breathing with or without apnea is characteristic of premature infants but may also be observed in term infants with central nervous system disease (intracranial hemorrhage, malformation or injury) or may be associated with hypoglycemia.

Cardiac Examination

Heart Rate: The normal resting heart rate in the newborn (140/min) is much higher than that in an adult or an older child. A heart rate in excess of 200/min is suggestive of a tachyarrhythmia. The exact type must be determined by an electrocardiogram. A slow heart rate ($<$ 40 to 50/min) may indicate congenital heart block.

Arterial Pulses: Both the brachial and femoral pulses must be examined. Reduced pulsations in all extremities is observed in severe congestive heart failure or the hypoplastic left heart syndrome. Diminished or absent femoral pulsations with normal brachial pulses is indicative of coarctation of the aorta.

Precordial Palpation. Excessive precordial hyperactivity, cardiomegaly (laterally displaced apical impulse) and thrills may point to a functionally important cardiac problem.

Auscultation: Presence of a single second heart sound (beyond 24 hours of age), gallop rhythm, ejection systolic click (after 24 hours) and cardiac murmurs may all focus attention to cardiac etiology of the distressed infant. Auscultation of the neonates is often difficult because of fast heart rates with equally elevated respiratory rates. In addition, the skills of auscultation are acquired only after carefully supervised training for months or years and have to be maintained by continuous practice, this is especially true in the neonate. Furthermore, cardiac murmurs are seldom helpful in the diagnosis in the newborn period. *About one-third of the infants with serious congenital heart disease have no detectable heart murmurs,[2] while infants without significant heart disease may have murmurs.* When murmurs are detected, they are not usually characteristic of a given heart defect and are much more variable in the neonates than in the older children and adults. An appreciation of the limitations of the auscultatory examination in identifying babies with heart disease in the neonatal period is imperative. "You don't need a murmur to diagnose severe con-

genital heart disease." Remember, the experienced pediatric cardiologist cannot often make specific anatomic diagnosis prior to cardiac catheterization but can only catagorize into broad functional groups.

Signs of Congestive Heart Failure: Congestive heart failure may manifest with signs of pulmonary or systemic venous congestion or altered myocardial function. Pulmonary venous congestion may present only with tachypnea. Rales and wheezing are uncommon in the neonate but irritability, difficulty in feeding and sleeping and cough are common. Hepatomegaly is the hallmark of systemic venous congestion in the newborn. In normal newborn infants, the liver is normally palpable 1-2 cm. below the right costal margin in the mid-clavicular line and should not be interpreted as hepatomegaly. Other signs of systemic venous congestion, neck vein distention and edema are rare in the infant and the latter when present may be atypical in distribution (periorbital or sacral). Finally, the signs of impaired myocardial function; tachycardia, cardiomegaly, gallop rhythm and decreased arterial pulses when identified should focus attention to a cardiac cause.

Other Physical Findings

Activity: A sudden deterioration of the infant's state of activity is frequently seen in patients with severe hypoxemia and metabolic acidosis secondary to CHD. They may be exhibited in the form of flaccidity, lethargy and failure to suck. These are ominous signs and may lead to death unless recognized and treated as an acute emergency. Ideally, the infant with CHD should be identified and referred prior to the appearance of these signs if an improved prognosis is to be expected. Other causes of these symptoms include intracranial pathology, metabolic acidosis, hypoglycemia, sepsis and shock of any type.

Sweating: Excessive sweating in the presence of normal ambient temperature may be suggestive of congestive heart failure and is probably a reflection of increased autonomic activity.[5] This sign is occasionally helpful in identifying infants with functionally important heart disease.

Laboratory Data

Chest Roentgenogram: Well positioned and good quality x-rays are essential for adequate interpretation. Antero-posterior and lateral projections of the chest are usually adequate without resort to barium administration. Chest roentgenograms help in categorizing infants with CHD into broad functional groups. Their major importance lies in their value in confirming or excluding non-cardiac causes of respiratory distress, namely pulmonary parenchymal disease, diaphragmatic hernia, esophageal atresia, pneumothorax and pneumomediastinum.

Cardiomegaly (greater than 60 per cent cardiothoracic ratio) when present is helpful in identifying infants with heart disease but poor quality films and superimposed thymic shadow often confuse the issue. Cardiomegaly may also be observed with hypoglycemia, asphyxia, hypervolemia and polycythemia. It is important to note that a small or normal-sized heart does not exclude CHD and indeed life-threatening heart disease may be associated with roentgenographically normal cardiac size; this is particularly true of the cyanotic heart defects.

Electrocardiogram (ECG): Interpretation of the ECG is difficult because of the normal right ventricular preponderance in newborns. It should be emphasized that the ECG is of little value in the initial diagnosis of cardiac disease in the noenate.

Hemoglobin and Hematocrit: Anemia and polycythemia may cause cardiorespiratory distress. Their role in cyanosis has already been alluded to. Polycythemia is considered to be present if the hematocrit is greater than 70 per cent.

Blood Gases and pH: Blood gas analysis confirms the presence of central cyanosis. Suffice it to say, that this laboratory procedure is of great value in correcting acid-base and ventilatory status during the initial diagnostic stages and transfer.

Glucose: Hypoglycemia has been reported to cause cardiomegaly and heart failure.[6] It has also been associated with severe congestive heart failure.[1] It is essential that blood glucose be monitored throughout the process of identification and transfer of the infant with CHD. Hypoglycemia is considered to be present if serum glucose is less than 30 mg% in the full term and less than 20 mg% in the premature.

TRANSPORTATION

Selection of infants for transfer: As soon as the distressed infant has been recognized and congenital heart disease is suspected, immediate transfer to a Regional Pediatric Cardiology Center is mandatory. All infants with signs of heart failure and/or hypoxia should be transferred. There will be some infants who, despite their abnormal cardiac findings, need not be transferred immediately. The infant with a murmur of a small ventricular septal defect, patent ductus arteriosus or peripheral pulmonic stenosis (latter two are more common in premature infants) or infants only with abnormal electrocardiographic findings are not candidates for immediate transfer. These infants should be referred to a pediatric cardiologist between two to six weeks of life. If at all possible, the parents of these infants should be spared

the anxiety, expense and inconvenience of transfer of their babies soon after birth. However, if any doubt exists as to the infant's cardiovascular function, the infant should be transferred immediately.

If there are no adequate facilities for immediate and safe transportation of the sick neonate from the community hospital to the medical center, early identification of the distressed newborn is futile. The pediatric cardiology centers are on "round-the-clock" call 365 days per year. Therefore, do not wait to call until morning or, if on a weekend until Monday. The type of transportation used, helicopter or ambulance is dependent upon the distance and the type of transportation available in a given area. In Georgia, where a large number of military bases are located, helicopter transportation is readily available and can be arranged through the pediatric cardiology center. The type of vehicle is not important but what it provides in the way of facilities for monitoring vital signs and for resuscitation is important. Unfortunately, weather conditions do not always allow for air transport, therefore, a community ambulance service must be available to all areas of our state. A sick infant should never have to be transferred by private automobile in the arms of a distressed parent or relative. The infant must be accompanied by a nurse, paramedic or physician.

Before and During Transfer

Upon identification of an infant with cardiac distress, the primary physician should make telephone consultation with his pediatric cardiologist and make arrangements for referral. A summary as well as xeroxed copies of all of the infant's and mother's charts should be sent with the baby. Most of these infants are likely to require blood transfusion and therefore 5 cc of maternal blood must accompany the infant. A thorough explanation to the parents of the need for the transfer of the baby and the procedures that the infant is likely to undergo at the medical center is the responsibility of the referring physician. The primary physician should also have the parents see and touch the baby and have the appropriate religious rites performed before transfer to the medical center.

Before and during the transfer, monitoring the infant's temperature and maintenance of a neutral thermal environment is extremely important. Facilities for continuous monitoring of infant's heart rate, and inspired oxygen concentration should be available. Metabolic acidosis, if any, should be corrected with sodium bicarbonate (usually 2 meq/kg as a "stat" dose). Hypoglycemia is a significant problem; therefore, the infant's serum glucose should be monitored and the infant should receive 10 per cent dextrose in water intravenously. Any other medications that may be needed (e.g., digitalis) should be administered after consultation with the pediatric cardiologist under whose care the infant is to be transferred. During transport, apart from facilities to monitor heart rate, infant's and incubator's temperature, and inspired oxygen concentration; facilities for suction, cardiorespiratory resuscitation including intubation and intravenous medication should be available. Only when meticulous care is given to the neonate prior to and during the transfer, can the infant be in optimum condition to undergo the diagnostic and therapeutic procedures successfully. Only then, will there be improvement in saving these babies. The potential for virtual cure of 80 per cent of distressed neonates is now available.

The transportation system required by the neonate, in fact, is what is needed throughout our state not only for the transport of neonates but also for critically ill adults and children. ■

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The findings from this study tend to agree with the results of similar polls in other parts of the country.

General Attitudes Concerning Certain Aspects of Medical Care in Tift County, Georgia

ROBERT P. WIGHT, JR., M.D., *Tifton**

This survey reveals a high degree of satisfaction with medical care given in Tift County, and a high regard for health professionals. Generally, it is thought that drug prices, hospital prices, and doctor prices are too expensive.

The strength of answers is quantified for each group surveyed; and the internal variability in answering a similar question twice is commented upon.

While health care is considered a right of citizenship by most respondents, national health insurance is strongly opposed by some groups and only moderately favored by others. There is a high level of satisfaction generally with private health insurance.

In mid March of 1974, an opinion survey was taken in Tift County concerning general attitudes of several aspects of medical care and medical needs in our county. This was done primarily with the view toward establishing some quantitation of the public's ideas of local medical needs; also, we desired to quantify opinions concerning larger general questions/attitudes regarding medical care.

The prompting influence for quantifying attitudes of local priorities was the fact that the community has a growing new hospital and it was felt local attitudes would be of some help in our establishing priorities in expansion. Also, such an opinion survey would serve as a good public relations tool it was felt.

The prompting influence for quantifying larger general questions regarding medical care was our local medical society's general dissatisfaction with the advent of PSRO, National Health Insurance, and probably a cascade of other federal health legislation. Would our local citizenry support ideas covering new health legislation predominant in the legislative and executive branches of state and federal governments?

The consideration of local need will not be reported in this paper, but the answers regarding larger questions of medical care needs compose the basis of this report.

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Methods

Questionaires covering 43 items were distributed to four different local groups of people. A sample of the questionaire appears at the end of this article.

The four groups surveyed were:

A. Rotary Club of Tifton (55 usable questionaires were returned);

B. The foremen of the local J. P. Stevens Textile Plants (68 usable questionaires were returned);

C. Random persons visiting patients in Tift General Hospital. These forms were distributed in the lobby of the hospital. (106 usable questionaires were returned);

D. Random distribution of people in the Town and Country Shopping Plaza Mall (105 usable questionaires were returned).

The author of this report distributed the questionaire to the Rotary Club (of which he is a member) just prior to a regular meeting of the group. The author also distributed the questionaire to the J. P. Stevens foremen two days prior to a monthly health safety meeting. The women of the Hospital Auxiliary distributed the questionaire in the Tift General Hospital lobby and the Town and Country Shopping Plaza Mall. The tally of the questionaire was done by the women of the Auxiliary and Mr. Vernon Griffin, administrative assistant of Tift General Hospital.

Results

I. Internal Variance of Questionaire Answers (See Table 1)

There is an internal variation on the answers to the questions depending on where they are asked in the questionaire (note question 5 and 18, and question 7 and 27).

TABLE 1

Question	Question Number	Yes % *R	†S	‡H	§M	No % R	S	H	M	Not Sure % R	S	H	M
Medicines fair priced?	5	36	8	32	27	29	59	34	51	35	33	34	22
Drugs fair priced?	18	24	25	27	35	35	55	39	48	41	20	34	17
MDs fair priced?	7	34	12	47	35	32	66	24	44	34	22	29	29
MD make too much?	27	41	50	28	54	26	22	27	33	33	28	45	13

* R—Rotary Club—55 questionaires.
† S—J. P. Stevens—68 questionaires.
‡ H—Tift General Hospital—106 questionaires.
§ M—Shopping Mall—105 questionaires.

Note that the J. P. Steven's foremen thought medicines were not fair-priced by a factor of 7:1 when asked in question 5, but by a factor of only slightly better than 2:1 when asked in question 18. This particular set of answers points out the range of variability in answering the same question twice in a somewhat emotional group . . . note the general direction of the answers does not change (medicines are too expensive). The other groups are more moderate, do not vary their opinion so widely, and give a mild-equivocal reaction that drugs are too expensive.

Similar observations are seen in the answers to questions 7 ("Are doctors' bills fair priced?") and 27 ("Do doctors make too much money?"). The Rotary Club is very equivocal as to whether MDs prices are fair in question 7, but slightly stronger in its feeling that MDs make too much money in 27. The Steven's foremen feel MDs bills are unfair by 5:1 margin in 7, but feel MDs make too much money by only 2:1 in question 27. Generally, all groups report the mild reaction that MDs are overpaid (with exception of respondents in hospital lobby . . . See III below).

Generally, it would seem that a consistent reaction (Yes or No) through all the groups polled of 3 to 1 or greater represents a strong reaction; a 2 to 1 consistent reaction for or against a question represents a mild reaction; and a 1 to 1 reaction for or against a question is equivocal. A high degree of variances in the strength of an opinion regarding prices of drugs and physician prices is noted, though they generally are considered too expensive (a mild reaction). This will be covered more fully below.

II. Adequacy of Medical Care (See Table 2)

There is generally a large reservoir of high regard for the medical care received in Tift County (a very strong reaction). There is very little difference in these answers, even in the reciprocating questions (questions 2 and 3). People are generally satisfied with the time their physician spends with them, physician competence, physician understanding of their problems, and physician explanations (a strong reaction). Furthermore, they did admire their child becoming a physician or a nurse (a strong reaction). As in other questions, it will be noted that the J. P. Stevens foremen tended to be somewhat more opinionated and perhaps somewhat more hostile than other groups polled. Overall, however, their reactions are generally in agreement with the other groups polled.

III. Cost of Medical Care (See Table 3)

Medical care is considered too expensive. (See Table 3. This is equivocal to a mild reaction.) Probably there is no significant difference in the rating of expensiveness of drugs, hospitals, and physicians. Interestingly, the location in which a question is asked has a strong bearing regarding the reaction to physician fees and income.

TABLE 2

Question	Question Number	Yes % *R	†S	‡H	§M	No % R	S	H	M	Not Sure % R	S	H	M
Overall adequacy of medical care?	1	84	75	85	63	8	2	5	24	8	23	10	13
Overall general care good?	2	87	60	88	78	2	20	2	9	11	20	10	13
Overall general care bad?	3	4	15	7	8	86	66	77	78	10	19	16	14
Level general MD care good in Tifton?	11	88	65	76	68	4	15	5	5	8	20	19	16
Adequate MD time spent?	13	75	48	66	53	19	46	26	44	6	6	8	3
MD competence?	14	92	84	87	81	2	8	5	14	7	8	8	5
MD understands problem?	15	85	68	82	73	5	21	7	16	10	11	11	10
MD explanation understood?	16	77	75	77	73	15	25	13	22	8	5	10	5
Admire child choosing profession?	26	88	67	72	79	8	13	13	12	4	20	15	9

* R—Rotary Club—55 questionaires.
† S—J. P. Stevens—68 questionaires.
‡ H—Tift General Hospital—106 questionaires.
§ M—Shopping Mall—105 questionaires.

TABLE 3

Question	Question Number	Yes % *R	†S	‡H	§M	No % R	S	H	M	Not Sure % R	S	H	M
Overall care fair priced?	4	33	7	33	32	36	62	27	44	31	31	40	24
Medicines fair priced?	5	36	8	32	27	29	59	34	51	35	33	34	22
Hospitals fair priced?	6	40	8	38	29	29	64	30	49	31	28	32	22
MDs fair priced?	7	34	12	47	35	32	66	24	44	34	22	29	29
Drugs fair priced?	18	24	25	27	35	35	55	39	48	41	20	34	17
Drug prices vary?	19	34	52	56	62	9	14	12	18	57	34	32	21
Should name of drug be on bottle?	20	87	91	90	91	4	5	5	7	9	4	5	2
Directions clear for taking?	21	88	91	94	85	8	5	3	3	4	4	3	4

* R—Rotary Club—55 questionaires.
† S—J. P. Stevens—68 questionaires.
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Persons polled in the lobby of the hospital (where presumably they were more acutely conscious of the physician's work) felt physician's prices were fair (a mild reaction); whereas, when one leaves the hospital setting the reaction becomes equivocal to negative (prices are too expensive). J. P. Stevens foremen felt strongly that all prices are too high. The more affluent Rotary Club is not as troubled about medical care prices, generally—note the reaction is equal on each item. In the shopping mall, which comprises a cross section of average households (probably more women) the reactions were generally stronger than the Rotary Club that the cost of hospital, drug, and physician fees are too expensive (mild-equivocal reaction).

IV. Socialized Medicine (See Table 4)

There is a moderate to strong reaction from all respondents that medical care is "a right" of American citizenship. It is probable that the respondents to question 22 mean access to medical care is a right, but do not necessarily mean government provided medical care is a right. In fact, there is a strong reaction against government-provided medical care from each sector polled. (See question 23.) Interestingly, the J. P. Stevens foremen were not satisfied with a check "Yes or No" on number 23, but had "Hell No" penciled in in many instances! While Rotarians and J. P. Stevens foremen (businessmen/white collar workers and blue collar workers respectively) felt strongly against National Health Insurance, the respondents in Tift General Hospital lobby and Tifton Shopping Mall felt National Health Insurance desirable (a mild reaction). Interestingly, the same respondents all agreed, across the board, that they are satisfied with their private health insurance (a strong reaction)! The general thrust of this section of questions answered in Table 4 is a notation of strong reaction against governmental intervention in the health care field.

V. AMA and MAG Awareness

The Tift County respondents are generally aware of the AMA and felt it is useful to the public. The

TABLE 4

Question	Question Number	Yes % *R	†S	‡H	§M	No % R	S	H	M	Not Sure % R	S	H	M
Medical care right of citizen?	22	57	61	75	71	29	15	6	12	14	24	19	17
Socialized Medicine desired?	23	10	16	21	26	78	61	42	54	12	23	38	20
Need National Health Insurance?	24	12	29	42	52	57	40	16	27	31	31	42	21
Satisfied with Present Health Insurance?	25	83	58	76	76	13	37	19	20	4	5	5	4

* R—Rotary Club—55 questionaires.
† S—J. P. Stevens—68 questionaires.
‡ H—Tift General Hospital—106 questionaires.
§ M—Shopping Mall—105 questionaires.

TABLE 5

Question	Question Number	Yes % *R	†S	‡H	§M	No % R	S	H	M	Not Sure % R	S	H	M
Aware of AMA as useful function?	29	47	35	57	60	10	15	3	6	43	50	40	34
Aware of MAG existence?	30	64	41	34	45	26	14	46	34	10	15	20	21
Is MAG useful?	31	40	26	33	42	10	12	2	10	50	62	65	48

* R—Rotary Club—55 questionaires.
† S—J. P. Stevens—68 questionaires.
‡ H—Tift General Hospital—106 questionaires.
§ M—Shopping Mall—105 questionaires.

same can be said for the MAG, in a lesser sense (mild reaction).

Discussion

The above findings tend to agree with the results of similar polls in other parts of the country at different times: 1) Lou Harris Poll, *Sacramento Bee,* June 10, 1974; 2) Bureau of Social Service, Inc. Poll, Washington, D.C. Area, June to August 1973, reported in the *Washington Post,* Sunday, March 17, 1974; 3) *Life Magazine* Survey, Volume 73, Number 6, August 11, 1972.

It is perhaps reassuring to health professionals to know of people's great depth of respect for physicians and nurses. Generally, people feel their doctor is competent, understands their problems, and explains his plans for treatment very well (a strong reaction).

They feel doctors make too much money (equivocal to mild reaction) except when interviewed in a hospital setting where it is felt MD prices are fair (mild reaction).

It is generally felt that drug prices are at least as unfairly expensive as any other sector of health care; and all drug names should be labeled on the bottle (strong reaction). Drug prices vary too much from store to store.

Nurses are not overpaid (strong reaction). Most of the persons polled are not familiar enough with the costs of nursing homes to state whether or not the cost is fair.

It is suggested that legislators would do well to know of the strong reactions of wage earners and businessmen against national health insurance and "socialized medicine." It is noted that random sampling of shoppers in the mall favor national health insurance in almost exactly the same proportions noted by the *Life Magazine* Survey and Lou Harris Poll. Persons interviewed in the lobby of the hospital are more equivocal regarding the desirability of national health insurance.

The strong satisfaction with private insurance is noteworthy. It is also somewhat surprising that the mall respondents who are satisfied with private health insurance by a 3:1 margin also favor national health insurance by a 2:1 margin. It is felt that the mall respondents represent mainly housewives whose views in favor of private insurance and against further intervention of federal government in health and other matters is not so strongly crystallized as that of businessmen and primary wage earners for the family.

It is felt that surveys such as the present one serve a good public relations function for community hospitals and medical staff as well as being informative.

Acknowledgements

The author wishes to thank Mr. Vernon Griffin for compilation of statistics, The Tift General Hospital Auxiliary for help in distribution of questionaires, Mr. Orville Ferrell, Tift General Hospital Administrator, and Mrs. Sarah Thompson, Administrative Secretary for help in preparation of typed script. ■

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

September 21, 1974

Appointments: Tenth District Representative on Professional Conduct and Medical Ethics Committee, Louis O. J. Manganiello, Augusta; Interspecialty Council (Gastroenterology), E. Napier Burson, Atlanta; Peer Review Committee (Surgery), Robert H. Stephenson, Atlanta; Clinical Laboratory, Blood Bank and Tissue Bank Advisory Council, Robert E. Perry of Brunswick as member, Earl G. Barton, Jr. of Decatur as first alternate and Jacqueline H. Werner of Riverdale as second alternate.

GRMP Liaison Officer, Luther H. Vinton, Avondale Estates; Ad Hoc Committee on Laboratory Quality, Philip E. Christopher, Decatur; Robert W. Smith of Atlanta, F. A. Sams of Fayetteville, Robert O. Stephens of Marietta and Lester Forbes of Atlanta; Mental Health Committee, Douglas Skelton of Atlanta and Mark A. Gould of Smyrna; Workmen's Compensation Medical Board, Albert M. Davis, Chenault W. Hailey, John T. Godwin and Richard A. Elmer, all of Atlanta, and Paul L. Bradley of Dalton;

Education Committee, James S. Maughon of Atlanta, R. Beauvois Randall, Jr. of Decatur; Micki C. Souma of Columbus, Carl L. Rosengart of Savannah, Nate E. Smith of Macon, Russell A. Acree of Hahira, Robert G. Ellison of Augusta, H. Harlen Stone and Harold L. McPheeters of Atlanta; Cancer Committee, LaMar S. McGinnis of Decatur; State Council Nursing Midwifery, G. B. Muller of Thomasville; Ad Hoc Committee to Study Physician's Assistants, John P. Wilson of Atlanta, Joseph M. Turner of Tifton, George F. Green of Sparta, William J. Morton of Cairo, C. E. Bohler of Brooklet, J. Rhodes Haverty of Atlanta and Carl Jelenko, Augusta.

AMA Clinical Meetings: Approved promotion program for MAG membership attendance at AMA Clinical Meeting in Portland, Oregon November 30 through December 4.

Physician Reimbursement Experimental Program: Approved submission of experimental CHEC (Certified Hospital Extention of Care) proposal to Social Security Administration for possible funding.

Confidentialty: Referred to Legislation Committee question of attorney access to medically privileged information on request rather than through court order.

GENERAL ASPECTS OF MEDICAL CARE IN TIFTON, GEORGIA

	Yes	No	Not Sure
1. Can you obtain adequate medical care for yourself and your family in this community?	—	—	—
2. Is the overall quality of medical care in this area good?	—	—	—
3. Is the overall quality of medical care in this area bad?	—	—	—
4. Is the overall cost of medical care fair priced?	—	—	—
5. Are medicines fairly priced?	—	—	—
6. Are hospitals fairly priced?	—	—	—
7. Are doctor's bills fairly priced?	—	—	—
8. Are nursing homes fairly priced?	—	—	—
9. Have you or your immediate family been a patient in a local hospital in the last two years?	—	—	—
10. Have you or your immediate family utilized local MD service in the last two years?	—	—	—
11. Do MDs in Tifton generally deliver adequate medical care?	—	—	—
12. What changes are needed:			
a. Cheaper surgical prices?	—	—	—
b. Cheaper medical prices?	—	—	—
c. Cheaper obstetric prices?	—	—	—
d. Cheaper children's prices?	—	—	—
e. Later office hours?	—	—	—
f. Greater access by phone?	—	—	—
g. Less waiting time in office?	—	—	—
13. Does your MD spend enough time with you during your appointment?	—	—	—
14. Are you statisfied with your MDs professional competence?	—	—	—
15. Does your MD usually understand your problem well?	—	—	—
16. Do you understand MDs explanations and prescriptions usually?	—	—	—
17. Should your doctor utilize a physician's assistant in helping care for you?	—	—	—
18. Are most drugs fair priced?	—	—	—
19. Do different drug stores' prices vary widely?	—	—	—
20. Should your bottle of drugs have the drug named printed on it?	—	—	—
21. Are directions for taking drugs usually clear?	—	—	—
22. Is medical care a right of U.S.A. citizenship?	—	—	—
23. Should we have "socialized medicine" or guaranteed national health care for everyone totally provided for by the U.S. Government?	—	—	—
24. Is there a need for national health insurance? (opposed to private health insurance)	—	—	—
25. Are you satisfied with your present health insurance?	—	—	—
26. Would you admire having your child become a doctor or nurse?	—	—	—
27. Do doctors make too much money?	—	—	—
28. Do nurses make too much money?	—	—	—
29. Does the American Medical Association serve a useful public function?	—	—	—
30. Are you aware of the existence of the Medical Association of Georgia?	—	—	—
31. Does the Association serve a useful public function?	—	—	—
32. Do you have any understanding as to why it is difficult to get all these things you checked? (i.e., first service, no waiting, low costs)	—	—	—

TIFT GENERAL HOSPITAL SERVICE

	Excellent	Fair	Poor	Not Sure
33. Overall performance in delivery of medical care	—	—	—	—
34. The ambulance service	—	—	—	—
35. Emergency room service	—	—	—	—
36. Overall nursing care	—	—	—	—
37. Care and service for ward patients	—	—	—	—
38. Billing and payment operation	—	—	—	—
39. X-ray services	—	—	—	—
40. Laboratory services	—	—	—	—
41. Food service	—	—	—	—
42. Availability of hospital bed space	—	—	—	—

43. Most needed to improve medical service in Tift area (number 1, 2, 3, etc.)

a. More medical doctors	—
b. More nurses and/or physician's assistants	—
c. Better ambulance service	—
d. Improved emergency room service	—
e. More hospital rooms	—
f. More nursing homes	—

Abdominal Mass and Non-Functioning Left Kidney in the Neonate

JOHN UFEMA, M.D. *and* TOM BLACKBURN, M.D., *Atlanta**

DR. JOHN UFEMA: This is the case of a 23-day-old male infant who was born after a full-term normal gestation. The newborn physical examination was recorded as normal. At the age of 23 days the infant was noted to be constantly crying and felt feverish to the mother. The physical examination was normal except for a 4 x 4 cm. abdominal mass which was palpable in the left abdomen. The initial radiographic examination consisted of frontal and lateral films of the abdomen. Dr. Blackburn, would you comment on these films?

Dr. Tom Blackburn: The most striking finding is the anterior displacement of intestinal gas shadows on the lateral film indicating a mass in the posterior abdomen (Figure 1). On the frontal film, there is not much to be seen to indicate the evidence of a mass demonstrated on the lateral film. The logical course in evaluation of a mass in an infant is an intravenous urogram. Was one obtained?

Dr. Ufema: These are the films on the intravenous urogram.

Dr. Blackburn: Again, on the preliminary film, I do not believe that the presence of an abdominal mass can be appreciated. A large amount of intestinal gas is present, obscuring both renal areas which is a common finding in infants and makes the evaluation of the excretory urogram difficult. There is evidence of function on the right with visualization of calyces and the renal pelvis. I do not see any evidence of a functioning left kidney. A 24-hour film fails to demonstrate any evidence of opacification of the left kidney.

This case falls within the category of a neonate with an abdominal mass and a nonfunctioning kidney. Statistically, in this situation, approximately ½ of the lesions are going to be of urinary tract origin. In this group, the two most common conditions are multicystic disease and hydronephrosis, with multicystic disease being slightly more common than hydronephrosis. Neoplastic processes are relatively uncommon in a situation such as this patient presents, probably less than 15 per cent.



FIGURE 1

Lateral film of the abdomen demonstrating anterior displacement of the intestinal loops by a mass in the posterior abdomen.

Multicystic Kidney Disease

Dr. J. L. Clements: A B-mode ultrasound scan was performed on this patient (Figure 2). This demonstrated a normal right kidney and evidence of a mass in the region of the left kidney, the mass did not represent a single cystic structure, the ultrasonic

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, Ga. 30322. The conference material has been edited by Doctors J. L. Clements and H. S. Weens.

scan demonstrated multiple interfaces of different density in the region of the mass, indicating a multiloculated nature.

Dr. Blackburn: To summarize, I believe that this represents multicystic kidney disease. In multicystic kidney disease, the kidney is so dysplastic that there is no function. With hydronephrosis, the delayed film may show some faint opacification of the hydronephrotic cavity or crescent-shaped opacification of residual renal tissue. The multicystic kidney disease is generally asymptomatic and is picked up on routine examination. There are several other things relating to the kidney that should be mentioned in the differential diagnosis. Infantile polycystic kidney disease is not a consideration in this case since this condition is bilateral and could be ruled out by the intravenous urogram. Wilms' tumor is unusual in the neonate and in an extremely rare case may result in a non-functioning kidney. Hamartoma of the kidney and renal vein thrombosis may result in this appearance on very rare occasions.

Dr. H. S. Weens: A point of practical consideration is that in patients with renal hamartomas the histologic appearance has been misinterpreted as Wilms' tumor. It is important that the true nature of the lesion be appreciated since hamartomas are benign lesions and no postoperative radiation would be required.

Dr. Blackburn: One other possibility that should be mentioned since the patient had fever and apparently sepsis is an abscess of the kidney, it is doubtful that this would result in complete non-functioning of the kidney, however. I believe that the most likely diagnosis in this patient is multicystic kidney.

Dr. Ufema: This patient underwent abdominal exploration and a multicystic lesion involving the entire left kidney was removed. Dr. Torres, would you discuss the pathology in this case?

Dr. William Torres: Grossly the kidney was multicystic and measured 4 x 4 cm. Microsopically, the kidney was multicystic with immature mesenchyme, poorly developed glomeruli and tubules, and islands of cartilage. These findings describe the entity known as multicystic dysplastic kidney. The ureter was not included with the specimen. At surgery, the ureter was atretic.

Comment and Review

Whenever a real abdominal mass is felt or suspected in a neonate, plain abdominal films should



FIGURE 2

Composite B-mode transverse ultrasound scan of the mid abdomen. The small arrows indicate a normal right kidney. The large arrows indicate a multiloculated cystic structure in the region of the left kidney.

be followed immediately by an intravenous urogram. Approximately 60 per cent of such masses will prove to be renal in origin. At times, the neonatal kidneys do not possess sufficient concentrating ability to produce adequate urinary tract opacification with standard doses, and the "total body opacification" technique is used. In this instance, from 2-4 cc/kg of contrast medium is injected, producing some opacification of all abdominal viscera. This may help in differentiating between cystic and solid lesions. The higher dose may also produce a satisfactory intravenous urogram in later films. Diagnostic ultrasound is at times helpful, as is cystoscopy in selected cases. The presence of a hemitrigone is indicative of a dysplastic kidney on the involved side. Statistically, the most common renal mass is the multicystic kidney, followed closely by hydronephrosis.

B-mode ultrasound scanning of the abdomen is of value in the evaluation of abdominal masses in the pediatric age group. It is possible to delineate the size and configuration of the mass and also distinguish between solid and cystic nature of the mass by the degree of penetration of the sound waves through the mass. ■

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Several challenging concepts are discussed.

Continuing Education for the Practicing Surgeon

JOHN P. WILSON, M.D., *Atlanta**

Comments by LaMar S. McGinnis, M.D., chairman of the Subcommittee on Medicine of the MAG Eduation Committee:

This article, penned by Dr. John P. Wilson, commends itself to those concerned with continuing education of physicians within the state of Georgia. As director of surgical education at Georgia Baptist Hospital for approximately 15 years, Dr. Wilson has been intimately involved in the training of surgeons. His concern extends beyond the formal training period to the continuing education of the practicing surgeon. His limited survey, thoughtful evaluation and well-conceived recommendations deserve consideration and action by medical school faculties, teaching hospitals, community hospitals and the Education Committee of the Medical Association of Georgia. The Medical Association was directed by the House of Delegates at its 1974 annual session business meeting in May to undertake a year-long study and evaluation of re-certification and re-licensure and to report in 1975 regarding its findings.

WHEN A SURGICAL RESIDENT finishes his training, he is probably more knowledgeable regarding the then current status of surgery than at any time in his life. He is generally a student up until the time he takes his "Boards." After this, the major compensation that accommodates for the relative diminution in knowledge in the course of time is the achievement of clinical experience which imparts ability that cannot be measured in terms of acquirement of current information, but is an essential part of competency in the practice of the art. The purpose of continuing education is to improve both knowledge and wisdom, primarily through the mechanism of imparting knowledge.

Why do some surgeons seem to freeze in a perpetual state of suspended animation from the time they finish their training throughout their surgical lifetime, while others continue to grow and expand and to assimilate the changes that occur in the specialty field? Solutions to problems require identification of the problem. The first question is, "What are the needs in continuing education, and how can we determine these?"

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Answers From Questions

From a recent questionnaire sent to a limited number of surgeons in private practice over the state in both small and large cities, the following conclusions can be drawn.

1. The *primary resources* for *continuing education* which are considered to be approximately equal in their value were: (a) Medical meetings (exclusive of hospital staff meetings), (b) Tape-recorded programs, and (c) Postgraduate courses. A few respondents listed medical journals as a source, but most, while they read journals, considered them a minor item in continuing education. There was also evidence of response to the effort (for example, the Medical College of Georgia Continuing Education Program) for organized medical school sponsored education at a local level.

2. A number of interesting comments were made regarding meetings. There was little difference in one-day and multiple-day meetings in terms of attractiveness to a practitioner. There is apparently a need for both. Several comments were made regarding the attractiveness of multiple-day meetings where wives can attend, and where there is also significant social activity included. All responding cited the program as the major factor in attracting them to a meeting, while over one half listed location as a factor, and rarely considered the other doctors attending the meeting as a factor (not to be misconstrued to mean faculty, which was listed as part of the program as a major factor in attractiveness). Again, it should be noted that hospital staff meetings were at the bottom of the list in being an effective educational mechanism.

3. In the *evaluation* of his continuing education, no respondent listed the appraisal of his continuing

education as "excellent" or "poor." Two thirds considered their continuing education "fair" and the remainder "good."

4. *Impediments* in continuing education boil down to one primary factor, "insufficient time." Several correspondents listed "unwillingness to make oneself do it" as a factor. This, of course, is a corollary to the problem of time. No respondent listed "expense," "unavailability or inappropriateness of meetings or journals" as impediments in continuing education.

5. Several specific suggestions were made. Audio and video tapes generally had high marks by those who used them. One respondent mentioned the beneficial impact of new men in the community on the quality of care, and several referred to postgraduate courses and "one subject" seminars as being beneficial.

6. *Most significant,* the majority of those responding without any suggestive question volunteered the opinion that there should be some type of requirement for continuing education. Re-certification at regular intervals was specifically suggested.

An interesting aspect of the results of this poll was the similarity to observations made in the Medical Association of Georgia Education Committee meetings where representation is multidisciplinary.

The remaining following observations are primarily personal opinions.

As so aptly identified by the respondents in the above-mentioned questionnaire, continuing education is basically a problem of time, but as a problem of time it has a number of facets. One of these is the ability to require oneself to do the things which are necessary. It is a matter of priority which allows one to place above and beyond other demands upon the time of the surgeon the need for continuing education in time preference to other activities. Over the course of better than 15 years, we have had as a part of our surgical residency training program a weekly journal "club." A review of current writings in surgery is only a small part of the purpose of the journal club. Far more important is the benefit that residents receive in developing the habit of learning how to continue their education, to develop the ability to separate "wheat from chaff" on the basis of the quality of the article, its source, its author, and importantly, its proper place in the perspective of surgical history and anticipated development.

Conclusions and Recommendations

There are several specific conclusions and recommendations that this author would offer in terms of continuing education.

1. Putting formal education and training of young men in the community. The best way to assure the continuing education of the private surgeon is to make him a teacher and student throughout his entire surgical lifetime. Current programs should be expanded and new ones developed to allow both medical students, interns and residents to rotate through community hospitals under the aegis of qualified surgeons. This is presently being done to a limited extent. It needs to be expanded. Nothing but good could come from such a program. The question of "learning bad habits" is spurious. There can hardly be a more pertinent training ground for the embryo surgeon than that which will be his environment for the better part of his surgical lifetime. And who learns more than the teacher?

2. Reassessment of the meetings. Anyone who has had to develop a program for a surgical meeting is aware of the problem of trying to offer a program broad enough to be attractive to a significant number of surgeons and at the same time being specific enough or limited enough in its scope to cover a subject in depth. We repeatedly hear comments by surgeons that they benefit most from programs which cover in depth a specific subject. Those persons responsible for surgical programs in the state and area need to correlate their efforts in this regard. It would be particularly appropriate for the major meetings in the state such as the Southeastern Surgical Congress, the Georgia Surgical Society, specialty surgical meetings, the Medical Association of Georgia, postgraduate courses from the medical schools, as well as the Georgia Regional Medical Program, and the American Cancer Society Workshop Programs to be correlated in some type of projected program so that minimal overlap and maximal coverage in depth can be made in the field of surgery.

3. Evaluation of continuing education. It is impossible to know how well one is accomplishing a desired purpose without some type of evaluation system. Almost all programs today in industry and education have a built-in evaluation system to determine whether or not their purposes are being fulfilled. The American College of Surgeons has developed the SESAP Program which is a self-evaluation program. It is quite obvious from this program that the major benefit derived is not necessarily an evaluation of the physician, but in prompting the physician to assess himself and to accomplish a great deal in continuing education by using the so-called "open book" type of examination to cover the field of surgery on a current basis. The greatest fault of the SESAP Program in this opinion, is that it is not mandatory. Most surgeons simply do not participate in a time-consuming

program such as this unless required to do so.

4. Re-certification. Most surgeons seem to appreciate the need or the inevitability of mandatory re-certification or re-licensure for the surgeon. Surgeons have repeatedly stated that they would accomplish continuing education if they were made to do so. At the present time, however, it is too easy to move continuing education down the list of priorities as long as it is not absolutely required. It is felt that such a program of re-certification applied in a reasonable and practical way could be of considerable benefit in continuing education for private surgeons. The merits of the various types of such a reassessment are not a proper subject for this article, but certainly simply requiring that surgeons take regular reassessment evaluations such as the SESAP provides at regular intervals would be a tremendous step forward.

To those who find re-certification repugnant and continuing education tedious, it might be pointed out that aside from the moral responsibility guaranteeing the American people the best health care possible, the medical profession from a practical standpoint will soon be required to demonstrate that it is, indeed, doing just that if it is to continue to exercise the prerogative of major decisions affecting health. ■

MAG Gains Specialists in Administration and Education as Staff Expands

A former AMA staff member, J. Sherwood Williams, has joined the Medical Association of Georgia in the newly-created position of assistant executive director, administration. As such, Mr. Williams will devote his time to surveying and evaluating services to members, will handle personnel policies, employee benefits and internal affairs of the Association staff. He has been assigned to the Emergency Medical Services, Occupational Health, Professional Conduct and Medical Ethics and Public Health committees.

Mr. Williams, 39, was born in Dayton, Kentucky and received his B.S. in business administration from Florida State University in Tallahassee, majoring in hotel and restaurant management.

In 1960 he joined the American Medical Association as ancillary meetings manager, gaining experience in the physical arrangement of meetings for five to 2,000 people. For two and a half years he covered five northwest states as an AMA field representative, then in 1967 became administrative assistant for the AMA Vietnam Medical Education Project in Saigon, helping provide more and better physicians for that nation. He worked in a similar capacity for the Vietnam Dental Education Project two years later.

As vice president of operations of the National Health Show, Inc. during 1969, Mr. Williams had complete responsibility for developing a 20-appearance exposition held in 20 locations. From September 1972 until coming to the MAG, Mr. Williams served the AMA as assistant director in the Department of Specialty Society Services.

Mr. Williams enjoys all water sports, especially scuba diving and water skiing, and involvement in choral groups during his free time. He met his wife, Michele, in Vietnam where at one time she served as an interpreter for the U.S. Government.



Williams (L) and Daniel join MAG.

The new position of assistant executive director, education has been filled by Stephen L. Daniel, Ph.D., whose primary duty will be to coordinate continuing medical education activities in the state. He will be involved with the planning of the fall scientific assembly to be initiated in 1975, as well as with MAG's accreditation of state programs in continuing medical education. Dr. Daniel will work with the medical schools, volunteer health agencies, government education agencies and will staff the Interspecialty Council and Education Committee.

Dr. Daniel, 36, comes to the Medical Association of Georgia from Marquette University in Milwaukee, Wisconsin where he served as an instructor of English for two years. He has a long career in the education and counseling fields.

The Minneapolis, Minnesota native and former member of the Jesuit religious order for nearly 18 years, received from St. Louis University his B.A., Ph.L. (licentiate in philosophy), M.A. in English and M.A. and M.Div. in theology. His Ph.D. in humanities is from Emory University.

As a planner and consultant, Dr. Daniel has designed college and high school curricula, including a comprehensive summer program to prepare inner-city youth for entrance into high school. He has edited a newsletter, served as faculty advisor for a high school literary magazine, and is working toward publication of his doctoral dissertation on the subject of interpretation theory and American poetry. His involvement in social work has been concentrated in the areas of employment, housing and family counseling.

Dr. Daniel's hobbies and interests include tennis, golf, camping, fishing, bridge, writing poetry, and keeping up with the fields of philosophy and religion.

editorials
editorials
editorials

Beyond Unicoi

THE DEVELOPMENT OF A MORE COHESIVE and responsive organization to carry out the increasingly complex problems of organized medicine was the goal of a planning conference at Unicoi, October 4-6, 1974. Convened by MAG President J. Rhodes Haverty, M.D., the dozen representative physicians attending were charged with the task of doing some free and open thinking about the way the Association functions and to suggest ways of changing or abolishing policies and practices that have not worked well.

Much of the two-day session was spent discussing the three governing bodies of the Association—the House of Delegates, Council and Executive Committee—as to the methods by which they are composed and the ways in which they approach their responsibilities. Avenues of "policy establishment," the function of MAG committees and the management of staff were discussed also.

House of Delegates

The primary suggestion concerning the House of Delegates was aimed at relieving the heavy burden of activity and responsibility left to the Council through the remainder of the year—namely, to have the House meet twice a year, in the spring and fall. Reference committees, it was felt, should be appointed at the end of one session to serve the next meeting of the House. These committee members thus would have six months in which to review materials they would have to consider at the next House of Delegates.

Other points suggested concerning the House were: 1) The speaker should be required to be a delegate to the House; 2) Presidents or secretaries of the county societies should be authorized to certify delegates when those elected and their alternates have not been able to attend; 3) Expenses for delegates should be paid by the county society; 4) Students and specialty societies should not have voting representation. Students, it was felt, are not yet practicing physicians and do not experience the same problems as those in





Exploring new ways for MAG to function are (L-R) Drs. Burgstiner, Johnson, Mauldin, Freeman and Fountain. President-Elect David Wells (R) explains a proposed organizational chart for Council and MAG committees.

practice. Specialty societies are represented adequately now, the conferees believed, and the House might become so large it would be ineffective. It now experiences a two to five per cent increase per year.

Council and Executive Committee

Suggestions concerning the Council were to reduce its size, adopt a more appropriate name and to reduce duplication of agenda items with Executive Committee.

The Council currently is composed of the elected officer group with councilors and vice councilors from eight councilor districts. In addition, county societies with 100 members are allowed one councilor; with 499 to 1,000 members, two councilors; and over 1,000 members, three councilors.

District societies were generally thought to be outmoded and ineffective. A different basis for electing councilors, such as medical trade areas might be more meaningful. Representatives from metropolitan areas should be retained. The conferees suggested eliminating the offices of immediate past president, first and second vice president and thought the MAG president should also serve as chairman of Council. In other points concerning officers, it was felt that the treasurer and chairman of Finance Committee should be the same person who, along with the speaker, vice speaker and secretary, would serve a two-year term of office and be eligible to serve three consecutive terms.

Citing "council" as a vague name that does not connote the function of this body properly to either MAG members or laity, a change in label to Board of Directors or Board of Trustees was recommended. This body would meet every other month on off months from the House of Delegates. The five officer members would serve as the Executive Committee and meet only at the call of the president.

Intra-Council committees should be set up along the lines of the current staff structure. These committees of two or three Council members would be responsible for the various Association committees and would present reports from them before Council.

In a further effort to streamline activity and time, voting members should be physically separated from non-voting members and guests at Council meetings.

Staff

With the addition of two new employees—assistant executive director, administration (J. Sherwood Williams) and assistant executive director, education (Dr. Stephen L. Daniel)—the staff has passed through a reorganization phase designed to create a more logical reporting system and structure.

The complete authority of the executive director over staff functions was applauded. Currently the procedure for employing new or additional staff personnel involves the Executive Committee making recommendations to Council for final action. The creation of new positions should be left to the Council for approval.

MAG Committees

It is at the committee level that policy-making procedures should begin in the Association, with committees serving as the original review agents for Council and Executive Committee. The committees should report their problems and findings to the intra-Council committees previously described, which in turn would report to Council. It was suggested that all committees should report to Council before issuing reports to the House of Delegates.

Policy Establishment

Conflicts have arisen in the past over who establishes policy as the House, Council, Executive Committee, president, secretary, executive director and committee chairman have at one time or another in the past sought to establish policy in the same area of activity. It was advised that a policy manual be developed and distributed along with a clear cut method of determining who should speak for the Association and under what conditions.

The various suggestions made at the Unicoi Conference have been referred to the MAG Committee on Organization and Functions and will be considered with deliberation by that group.

"MEDIC ALERT" DESIGNED TO HELP YOU SAVE LIVES

One in five Americans, the AMA reports, has a special medical condition—which in an emergency could mean a matter of life or death if not communicated properly to medical personnel. The problem is even more serious if the patient is unconscious or otherwise unable to speak for himself.

Since 1956, a California-based, non-profit organization, Medic Alert Foundation, has been meeting the need by providing bracelets and neck disks on which medical information is engraved, backed up by a wallet card and 24-hour data system for quick reference in an emergency. A renewed effort is being made to make sure the public is aware of this life-saving service and that medical personnel look for and recognize the emblems. In some cases tags have been removed as jewelry and the danger-alerting information missed.

The bracelet or neck disk bears the caduceus and the words "Medic Alert" on one side, and the immediate primary problem or problems on the reverse. In addition, the wearer's code number to Medic Alert and the telephone number of the Foundation's Central File on over a half million member Americans is given.

The computerized data system accepts telephone calls 24 hours a day from authorized persons such as physicians, emergency room personnel and law enforcement officials. The code number is read off the emblem and a more detailed file of information is retrieved which includes the names and addresses of the wearer's physician and nearest relative. Each member is provided with a computer printout yearly so that he may review his record with his physician, insuring that it is current and complete. The file is designed to be an accurate extension of the care his physician would like him to receive in a medical emergency.

Among the more common medical problems listed on the emblems are: "Allergic to Penicillin," "Diabetes," "Epilepsy," "Taking Anticoagulants" and "Wearing Contact Lenses." Civil Defense authorities are recommending that everyone carry information concerning his blood type. The Medic Alert emblems are the perfect answer to any problems that might be encountered in emergencies in which this information might be needed—they won't become worn or unreadable, they can't be destroyed by fire or water and you can't lose them.

Pamphlets, posters and application forms are available for personal use or display in waiting rooms and offices. Contact Medic Alert Foundation International. P. O. Box 1009, Turlock, Calif. 95380.

president's letter



Talking With People

NOT LONG AGO I ATTENDED a seminar put on by the Hospital Corporation of America, primarily concerning the medical audit. The local medical staffs in each of their individual hospitals set the criteria that they wish to use in their medical audits. However, because of the corporate nature of the chain, they can then compare their own criteria with those of other affiliated members, and then can compare the results of these audits from one hospital to another. Talking with people ends up bettering things for patients and making things easier for physicians.

Over the past few months, some of your officers have been having discussions with the editorial staffs of several of the major newspapers in our state. We are offering them our knowledge, assistance, and experience, and urging them to call us when they are writing news, features, or editorials, about the practice of medicine. Hopefully this will build a rapport that will be useful to the media, informative to their readers, and perhaps a bit gentler to the medical profession. Talking with people.

Talks have just begun among the Georgia Hospital Association, the two Foundations, the Blues, and MAG attempting to develop a common approach toward concurrent medical review of hospitalized patients. It seems almost foolish that we have not gotten together before—all together—and perhaps this is why we have some of the problems we have. I would hope that mutually acceptable solutions to this kind of problem will be ironed out by the simple mechanism of getting together and talking.

There are other kinds of "getting together." We have had a meeting at the headquarters office with the president and legislative chairman of the Georgia Podiatry Association. Our Joint Practice Committee between Medicine and Nursing meets regularly. I hope to initiate and keep up with meetings between organized medicine and other groups that relate to the delivery of health care in our state.

Talking with people. This can be reassuring, inquiring, responding, exploring, reacting. Whatever comes out, it has got to be better than not talking at all. Even if such discussions end up agreeing to disagree, we are no worse off than before, and should any areas of compromise or unity of purpose or action surface, it would have been well worth it. Talking with people. Let's do more of it, both at the state level, as well as right there in your own community.



John Rhodes Haverty, M.D.
President, Medical Association of Georgia

Why Accelerators in Radiation Therapy?

JOHN R. MCLAREN, M.D., *Atlanta**

WITHIN RECENT YEARS all have appreciated spinoff of space-age gadgetry in various fields of medicine. Likewise, the development of supervoltage radiation therapy units awaited the technology of World War II.

Some of the pioneers of X-ray technology in the 1920's postulated and demonstrated two advantages of supervoltage: 1) greater penetrability with improvement in ratio of tumor to normal tissue doses (therapeutic ratio), and 2) gradual build-up of electron scatter from the surface to a maximum at some depth below the basal layers of the epidermis, thereby lessening skin reactions. These ingenious and industrious workers collected limited but sufficient quantities of radium to construct "radium packs" which were adequate for patient treatment but necessarily at short distances because of inadequate source strength.

Bomb Shelter Inspiration

While in a bomb shelter during one of the blitzes of London in World War II, Robert Grimmett designed a therapy unit in which Cobalt-60 at hectocurie levels would replace radium, and a few years later built a kilocurie unit. It should be noted that during this time Emory University Medical School, with Georgia Institute of Technology and the Oak Ridge Institute of Nuclear Studies, developed a hectocurie unit which was used for many years at the Robert Winship Memorial Clinic of Emory University Medical School. Dr. Frank E. Morgan worked with this unit and co-authored one of the early papers describing development of Cobalt-60 teletherapy units. With abundant supplies of Cobalt-60 at reduced prices 8000 curie units were manufactured which permitted treatment at greater distances and resultant further improvement in the ratio of tumor to normal tissue doses. Unfortunately, although ideal in many ways, these teletherapy units possessed some inherent disadvantages and many scientists worked years to develop electronic accelerators which would give improved beam characteristics.

The betatron, which accelerates electrons in a circular path within a donut-shaped tube, was developed concurrently by Dr. Shittenhelm in Germany and Dr. Kirsh of the United States, both independently overcoming many common problems while making the same mistakes because of wartime secrecy. During this same interval, Drs. Alvarez and Frye of Europe and Hanson and Grinzton of the United States, using electron technology developed during World War II, succeeded in accelerating charged particles and later electrons down a linear tube. In the betatron, the electrons are pushed and pulled by means of pulsating alternating magnetic fields, and in the linear accelerator, by an intense radio frequency wave. In both instruments the electrons may be extracted as high energy particles of ionizing radiation or they may strike a target and exit as high energy X-rays. The betatron recycles the electrons which escape the target and is somewhat more efficient than linear accelerators and less expensive. Betatrons are sources of intense electron

* Director for Radiation Therapy, Emory University School of Medicine, 1365 Clifton Road, Atlanta, Ga. 30322.

beams and adequate X-ray beams for therapeutic purposes. Linear accelerators produce intense sources of both electrons and X-rays; therefore treatment times are somewhat shorter and increased treatment distances are possible. The emerging beams are of importance in medicine, not their place or mode of birth.

The advantages of these particular beams over the Cobalt-60 supervoltage sources are:

1. Intervening tissue sparing—with the more commonly used 4 MeV linear accelerators—this is only slightly better than that of Cobalt-60 (5 mm) but increases to 4 cm for 25 MeV machines.
2. Less penumbra with resultant better defined beams and less tissue volume irradiated for fields of equal size.
3. Higher output which permits therapy at greater distances and use of larger, more complex treatment fields.
4. A nearly constant output over long spans of time—Cobalt decays so that the output decreases at approximately 1 per cent per month with appreciable decay costs.
5. High reliability (most of the time)—maintenance costs are significantly higher than Cobalt-60 units, but are comparable to Cobalt-60 decay costs.
6. Useful electrons (more energetic) may be produced. Unlike X-rays, electrons have mass and a finite penetration into tissues so that normal tissues beyond a tumor may be spared the effects of ionizing radiation. The more energetic accelerators offer a choice of energies for treatment. The maximum energy available is primarily a function of the number of inflated dollars one has and wishes to put into his unit. Both betatrons and linear accelerators are commercially available up to 45 MeV.
7. Accelerators, particularly linear accelerators, are currently the "in generation" of supervoltage units.

The accelerators currently in use show primarily those physical advantages for which "radium packs" were built. No matter how sophisticated, the "now generation" of accelerators will not overcome the radioresistance of anoxic cells present in larger tumors. Accelerators of pions and neutrons which will help eliminate the differential radiation damage secondary to differences of oxygen tensions are currently being tested in various parts of the world. Accelerated pions, and argon and neon ions in addition to this radiation biological advantage, also offer physical advantages whereby large volumes of intervening normal tissues between the surface and the tumor are protected as well as tissues beyond the tumor as seen with electrons. These units are quite elaborate and their prices start at over $1 million. ■

HIGHLIGHTS OF COUNCIL
September 21-September 22, 1974

Appointments: Alternate Directors for the Georgia Medical Care Foundation, Joe L. Nettles, Savannah, First District, Lucien A. Flint, Canton, Ninth District, William Rawlings, Sandersville, Tenth District; GRMP Liaison Officer, Luther M. Vinton, Jr., Avondale Estate.

Hawaii Tour: Approved sponsorship by MAG of Hawaii tour in conjunction with 1975 AMA Clinical Convention.

EMCRO Criteria: Approved submission of request to specialty societies for use of EMCRO criteria by the Georgia Medical Care Foundation.

Physician Manpower Study: Approved expenditure of $4,400 for beginning phase of Physician Manpower Study by MAG Research and Development staff.

Cancer Management Network: Voted to withdraw support from breast cancer project and SEER (Surveillance, Epidemiology and End Result) projects.

PSRO Repeal: Reaffirmed opposition to PSRO with no further special expenditure of MAG funds for repeal efforts.

Scientific Assembly: Committed MAG to planning for Scientific Assembly to be tentatively held December 5, 1974 at the Fairmont Colony Square Hotel in Atlanta.

National Legislation—RMP, CHP and Hill Burton Reorganization: Discussed possible National Legislation changing these programs with the possibilities that RMP may cease to exist as a separate organization effective July 1, 1975. Voted to support AMA position to extend RMP and CHP legislation for an additional year.

Laboratory Quality Legislation: Heard report on possible state legislation to control physician office laboratories. Referred for study to the Laboratory Quality Committee for report.

heart page
heart page
heart page

Is Atherosclerosis a Childhood Problem?

WILLIAM B. STRONG, M.D., *Augusta**

ATHEROSCLEROTIC EVENTS (defined here as a myocardial infarction or cerebrovascular accident) are rare in the first two decades of life. The incidence of these diseases peaks in the sixth and seventh decades of life. Therefore, we can say atherosclerosis is not a pediatric problem. *But can we?* All of the accumulated autopsy data strongly suggests that the pathology of atherosclerosis begins early in life and is often a well established process by the time an individual is 20 years of age. These were the conclusions of Dr. Enos and Associates[1] and Dr. McNamara's[2] group who studied the coronary arteries of United States servicemen killed in the Korean and Vietnam wars. Young men, averaging 22 years of age, had significant coronary pathology—5 per cent of them having all three coronary arteries involved or critical coronary stenosis. The data of the International Atherosclerotic Project[3] confirmed these studies and demonstrated that the earliest lesion of atherosclerosis, the fatty streak, is seen as early as three years of age and is uniformly present by 10 years of age.

Progressive Stages

It is the thought of many that the atherosclerotic process begins in childhood and progresses through stages to its final clinical manifestation in middle and late adult life. Therefore, atherosclerosis does not just develop "de novo." Atherosclerosis does not "just happen" like an upper respiratory infection. The 45-year-old who has a heart attack has been incubating his disease a long time. There is a prolonged latent period from onset of process to clinical manifestations.

If we are to have any effect on the reduction of atherosclerosis, our efforts and attention must be focused on the child. We should first seek out those children who are at high risk of developing a premature atherosclerotic event (i.e., prior to age 50). Children at highest risk are the following:

1. Children whose parents or grandparents have had an atherosclerotic event prior to age 50.
2. Those with a family history of hypercholesterolemia.
3. Children with abnormally elevated blood pressure (often a familial characteristic).
4. Diabetic children.

Children who possess any of the above risk factors should receive nutritional and physical activity counseling, as well as non-smoking education. Excessive ingestion of cholesterol, calories and salt, lack of physical activity to "burn off" calories or tone the cardiovascular system and smoking are the only areas in which we can presently intervene. More knowledge of the cause of atherosclerosis is needed in

* From the Department of Pediatrics, Section on Pediatric Cardiology of the Medical College of Georgia, Augusta, Ga. 30902. Prepared at the request of the Committee on Physician Education of the Georgia Heart Association.

order for the most rational attack. However, enough circumstantial evidence implicates the above factors to make it seem worth while to do "something about them."

The general population should also be educated as to proper nutrition, and what constitutes adequate exercise to benefit the cardiovascular system. Educational programs should be directed at youths between the fifth and twelfth grades.

Augusta Pilot Project

A pilot program to evaluate and counsel children at high risk of atherosclerosis has been implemented in Augusta at the Medical College of Georgia. The initial phase of the program is to enroll children and grandchildren of individuals who have had an atherosclerotic event prior to the age of 50. These children will have serum cholesterol and triglycerides measured as well as receive nutritional counseling from a nutritionist concerning total calories, cholesterol and salt consumption. In addition, exercise activities which promote cardiocirculatory fitness will be recommended.

If the progression of atherosclerosis is to be delayed or prevented, I believe we must turn our thinking to the child. ■

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2. McNamara, J. J., Malot, M. A., Stremple, J. F., et al.: Coronary artery disease in combat casualties in Vietnam; *JAMA* 216:1185-1187, 1971.
3. McGill, H. C.: Introduction to the geographic pathology of atherosclerosis; *Lab. Invest.* 18:465-467, 1968.

DECEMBER COURSE REVIEWS PROBLEMS IN "STABILIZING THE EMERGENCY PATIENT"

A 2½ day course on "Stabilizing the Emergency Patient" which features workshops and lectures designed to provide an update on emergency intervention and related patient care is scheduled for December 2-4, 1974 at the Atlanta Internationale Hotel.

The program was developed by the Medical Association of Georgia upon recognition of the development in this state of what has become a national phenomenon —the use by the public of the hospital emergency clinic as the primary point from which to enter the health care system. Both the transient nature of our society and the increasing specialization of medicine have led to this development.

In response to this phenomenon, community hospitals increasingly require rotation of physicians to cover the emergency clinic. Some physicians have developed a full time practice in emergency medicine, gravitating into this "second career" from family or specialty medicine. It is for these physicians that this course is designed.

A $125 registration fee will be charged for the course, which is co-sponsored by the Georgia Chapter of the American College of Emergency Physicians and the Georgia Society for the Prevention of Blindness. Contact the Medical Association of Georgia for additional information.

Cafe Coronary to Coma

Course topics include: The Heart—cardiac tamponade, complications of myocardial infarction, cardiopulmonary resuscitation, workshops on cardiopulmonary resuscitation; Respiratory Problems—management of airway obstruction ("cafe coronary"), chest wall injury/pneumothorax and hemothorax, pulmonary edema, and workshops on intubation; Shock—pathophysiology of shock, shock-management and monitoring, workshops on interpretation of chest x-rays; Coma and the Eye—differential diagnosis of coma, metabolic comas, intoxicants and overdose, convulsive disorders and eye emergencies. The final day's program will include: organizing the emergency department, legal aspects of emergency care, emergency medical technicians in Georgia and workshops on interpretation of the EKG.

Visiting Faculty

The visiting faculty is made up of Neal L. Chayet, LL.B., lecturer at Boston University School of Law and Tufts University Schools of Medicine and Dental Medicine; William T. Haeck, M.D., president of the American College of Emergency Physicians from Jacksonville's Memorial Hospital; David Knott, M.D., medical director of the alcohol and drug clinic of Tennessee Psychiatric Hospital and an assistant professor in the departments of psychiatry and family medicine at the Univerity of Tennessee School of Medicine; and Peter Rosen, M.D., professor and director of the Division of Emergency Medicine at the University of Chicago Hospital and Clinic.

The Medical Association of Georgia faculty includes Howard S. Brown, Robert P. Cunningham, William L. Dixon, Richard Franco, John E. Frazier, II, Selwyn T. Hartley, Carl Jelenko, Henry C. Johnson, Jr., Barry Silverman, John E. Steinhaus, John H. Stone, Peter Symbas, L. Newton Turk, III, H. Kenneth Walker and William C. Waters, III.

legal page
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Deductibility of Travel Expenses Incurred by Physicians

MARC HEILWEIL, *Atlanta**

MANY PHYSICIANS FIND THEMSELVES traveling several times a year in order to attend professional conventions, seminars or Medical Association business meetings. The Internal Revenue Service is examining more closely the circumstances surrounding the expenses incurred by professional persons on such occasions.

A recent revenue ruling denied to a physician any deduction for expenses for a 14-day trip to two foreign countries which was sponsored by his local medical association.† The object and design of the trip was to combine travel to certain cities in two foreign countries with several professional seminars in each country. Each seminar lasted only two hours. The seminars were held in each country at the hotel where the physician stayed, and he signed attendance sheets. The Internal Revenue Service found that the attendance at the seminars did not convert what was essentially a vacation into a business trip. Therefore, the entire expense of the trip was ruled to be non-deductible. Had there been any expense directly attributed to the seminars, it would be allowed as a deduction. Travel and related expenses ("expenses") would still not have been deductible.

Primary Purpose

The expenses of a physician are, in general, deductible if the trip was primarily to further his practice or improve his professional skills. In determining the primary purpose of a trip the most important factor is the number of days spent on professional as opposed to personal pursuits. The process of determination need not be totally mechanical. For example, a surgeon might find it necessary to journey in order to observe a certain procedure. He could still consider the trip as business even though he spent several additional days visiting friends. The extent to which he could take deductions is considered below.

Attendance at meetings of medical societies and conventions ordinarily qualifies as a professional activity. The IRS did, however, issue a news release this year stating that it would closely scrutinize certain conventions, cruises and trips during which only a small portion of the time is devoted to business activity. If it appears the primary purpose of an individual's attendance was to take a vacation, the expenses will be disallowed.

In general, when traveling abroad, only that portion of the total expenses attributable to business is deductible. Expenses of a trip abroad are not deductible to the extent that they are allocable to personal activities. Assume, for example, that a physician traveled to Brazil primarily for a professional purpose. However, only eight days of his two weeks of traveling were devoted to professional activities.

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* Prepared at the request of The Medical Association of Georgia. Mr. Heilweil is an associate in the firm of Powell, Goldstein, Frazer and Murphy, General Counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, 35 Broad St., Atlanta, Ga. 30303.

† Rev. Rul. 74-292, I.R.B. 1974.

Only 8/14 of the trip's expenses are deductible. His expenses of board and lodging on the days when his professional activities were conducted are deductible. No such allocation is necessary if a trip lasts for no more than one week and less than 25 per cent of the time away from home is spent on personal matters. The days spent en route on such a trip abroad are counted as business days.

The above rules do not, however, apply to travel within the United States. The difference is that all expenses en route are deductible when traveling domestically so long as the trip is primarily for a business or professional purpose.

Spouse Expenses Deductible?

Another question which frequently arises is whether the expenses of spouses are deductible when they go along on a business trip. There are two critical questions in determining this issue. First, whether the dominant purpose of the spouse's trip was to serve the other spouse's business or professional purpose in making the trip; and, second, whether the accompanying spouse actually spent a substantial amount of time in assisting the other in fulfilling that purpose.

In ruling on this question, courts have consistently refused to allow deduction of the spouses' portion of expenses when their business role was only nominal. It has not been sufficient that the other spouse was assigned incidental secretarial tasks or a minor role in arranging activities. More generally, unless employed in a *bona fide* capacity, one spouse must be required, because of the other's business needs, to make the trip.

One case in which the Court did allow deductions of a spouse's expenses on a business trip involved Roy Disney, brother of the famous cartoonist. In order to represent properly its image abroad, the Disney Company insisted that its executives should be accompanied by their wives. In light of this policy, the Court found that the Company's reimbursement of Mrs. Disney's expenses was proper.

It is very important to remember that substantiation of this kind of travel and entertainment expense is also necessary. No deductions will be allowed for any travel or entertainment expenses unless the following elements are substantiated:

1. the amount of the expense or other item;
2. the time and place of the travel or entertainment;
3. the business or professional purpose of the expense or other item; and
4. the business or professional relationship of the person entertained.

Substantiation of travel or entertainment expenditures should be kept in an account book, diary, statement of expense, or similar record (supported by adequate documentary evidence) that is sufficient to establish the above elements.

This article touches on only a few of the key points in considering whether an expense is deductible. Before incurring substantial travel expenses which have some business connection, a physician would be well advised to consult his attorney as to tax aspects of the trip.

I've told this before . . . .

(Ed. note: We have a new contributor to this feature page as Medical College of Georgia Professor Carl Jelenko shares the story of an irascible appendectomy patient who had the last word. If you have a favorite story to tell, send it to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

There, but for the Grace of God

ALMOST 15 YEARS AGO, one of my teachers, an accomplished surgeon in a small Maryland community, performed an appendectomy on a crusty local fisherman. The appendix was ruptured; the surgery tedious; and the post-operative course stormy. Day after day the physician visited his patient who remained distended with ileus and who complained of both his nasogastric tube and his abdominal discomfort.

About six days after the patient's operation, in the middle of the evening, the surgeon himself developed the hallmarks of acute appendicitis. That same evening, his partner removed the physician's acutely inflamed appendix.

In the morning, partially doubled with incisional discomfort, the surgeon-patient got himself out of bed, put on his bathrobe, and went out onto the ward to visit the old fisherman. "Why aren't you out of bed?" he addressed him. "Doc, I'm sick—I'm blown up—my belly hurts! I've had an operation!" replied his patient.

"Look, George," said the Doctor, "I had my *own* appendix out last night and *I'm* able to walk around here to see you."

The old fisherman regarded him balefully. He turned his head and fixed him straight in the eyes. "Yes, Doc," he said, "But *you* had a different surgeon!"

Carl Jelenko, III, M.D.
Professor of Surgery
Medical College of Georgia
Augusta, Georgia 30902

The Diabetes Unit of Emory University School of Medicine and the Georgia Department of Human Resources present:

Modern Methods of Diagnosing and Treating Diabetes Mellitus and Its Complications

This is an on-going course of instruction for physicians who are interested in a comprehensive review of up-to-date methods of managing diabetes mellitus. The course will be offered on a Tuesday or Thursday each week for 10 weeks. This session will begin February 4 and February 6, 1975. There is no tuition fee. The course is approved for 50 hours of postgraduate work by the Georgia Academy of Family Physicians.

Those interested in registering for the course should contact: Dr. John K. Davidson, Diabetes Unit, Emory University School of Medicine, 69 Butler Street, S.E., Atlanta, Georgia 30303. Phone (404) 659-1212, Ext. 797, and ask for Mrs. Alogna.

the association
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NEW MEMBERS

Blackman, William M. Whitfield-Murray—Act—Oph	1217 Memorial Dr. Dalton, Ga. 30720
Blalock, Tully T., Jr. MAA—DE-2—I	Emory Univ. Hosp. Atlanta, Ga. 30322
Bonau, Rogelio Newton-Rockdale—Act—Su	5303 Adams St. Covington, Ga. 30209
Brown, Dempsey S. Bibb—Act—Su	740 Hemlock St. Macon, Ga. 31201
Carroll, Michael S. Cobb—Act—Al	2480 Windy Hill Road Marietta, Ga. 30062
Chorches, Michael A. MAA—Act—C	265 Ivy St., N.E. Atlanta, Ga. 30303
Colier, Howard J. MAA—Act—C	6287 Fairburn Road Douglasville, Ga. 30134
Cousins, William L. Cobb—Act—I	792 Church St. Marietta, Ga. 30060
Eyzaguirre, William A. MAA—Act—C	5064 Nandina Lane Dunwoody, Ga. 30338
Felner, Joel M. MAA—Act—C	Grady Mem. Hosp. Atlanta, Ga. 30303
Fletcher, Melvyn R. Cobb—Act—Pd	122 Cherry St. Marietta, Ga. 30060
Griffin, Basil M., Jr. MAA—Act—Or	960 Johnson Ferry Road, N.E. Atlanta, Ga. 30342
Jarrell, Shelby E. Crawford W. Long—Act—EM	1230 Baxter St. Athen, Ga. 30601
Kelleher, Robert M. Cobb—Act—D	50 Plaza Way Marietta, Ga. 30060
Lord, Clyde O. MAA—Act—Anes	501 Fairburn Road, S.W. Atlanta, Ga. 30331
Marriner, E. F. Hall—Act—OcM	Chicopee Manuf. Co. Gainesville, Ga. 30501
Mathis, Ernest H. MAA—Act—ObG	3200 Howell Mill Road Atlanta, Ga. 30327
McCord, Dale L. MAA—Act—R	25 Prescott St., N.E. Atlanta, Ga. 30308
McKinney, James E. Whitfield-Murray—Act—U	Medical Arts Bldg. Dalton, Ga. 30720
Meehan, Peter L. MAA—A—Or	Georgia Baptist Hosp. Atlanta, Ga. 30312
Phillips, Thomas W. MAA—Act—R	25 Prescott St. Atlanta, Ga. 30308
Prince, Alan D. Cobb—Act—N	50 Plaza Way Marietta, Ga. 30060
Safwat, Mohamed MAA—A—Su	1501 Clairmont Road Decatur, Ga. 30030
Samara, David J. Sumter—Act—U	212 Reese St. Americus, Ga. 31709
Shantha, Totada R. MAA—Act—Anes	384 Peachtree St., N.E. Atlanta, Ga. 30308
Siller, Everard J. MAA—Act—N	Monastery of the Holy Spirit Conyers, Ga. 30207
Snead, Joseph A. Sumter—Act—Or	1102 E. Lamar St. Americus, Ga. 31709
Teh, Jack B. Whitfield-Murray—Act—Path	Hamilton Mem. Hosp. Dalton, Ga. 30720
Verley, Karl W. MAA—Act—ObG	2945 Stone Hogan Road, S.W. Atlanta, Ga. 30331
Von Haam, Emmerich, Jr. MAA—Act—Or	2788 Bayard St. East Point, Ga. 30344
Whittle, Michael R. Coffee—Act—Path	Coffee Gen. Hosp. Douglas, Ga. 31533
Wilkiemeyer, Ralph M. MAA—Act—U	3250 Howell Mill Road Atlanta, Ga. 30327
Yun, In W. Jefferson—Act—FP	809 Estelle St. Wrens, Ga. 30833
Zaki, Saleh A. MAA—Act—Path	62 Butler St., S.E. Atlanta, Ga. 30303

SOCIETIES

A resolution adopted by the **Bibb County Medical Society** requests the Macon-Bibb County Hospital Authority to reconsider its position to close the Medical Center School of Nursing, especially since an effort is currently being made to open a medical school in the area. Joint reports of the Society and its Auxiliary were given at the regular monthly meeting in October.

The October 21 meeting of the **DeKalb County Medical Society** featured a program on the topic of much national interest, acupuncture, led by Yung-Fung Sung, M.D., from the Department of Anesthesiology of

Emory University Hospital. The Society's Auxiliary presented an Art Exhibition and Auction October 26 to benefit AMA-ERF (American Medical Association Education and Research Foundation).

James E. McCranie, chairman of the Department of Psychiatry at the Medical College of Georgia in Augusta was the guest speaker for the October meeting of the **Georgia Medical Society.**

Nominations for offices in the **Medical Association of Atlanta** were presented at the Society's October meeting. Contested races will be decided by mail ballot and the winners announced in December. L. Newton Turk, III, an Atlanta thoracic surgeon, was nominated unopposed as president-elect for 1975. In other races, William C. Collins and Hugh S. Thompson were nominated for treasurer; F. William Dowda and Harry L. Cheves for trustee-at-large; J. Watts Lipscomb, Armand E. Hendee and David E. Dalrymple for another trustee-at-large post. William B. Spearman and Milton Frank, III face each other for central district trustee and Joseph S. Wilson and Allan Bleich are candidates for a judicial council position.

PERSONALS

First District

Sanford V. Berens of Savannah, head of the nuclear medicine section of the radiology department of Memorial Medical Center, has passed the written exam of the American Board of Radiology. Dr. Berens is a diplomate of the American Board of Radiology, nuclear medicine and radiation therapy. He is a member of the Society of Nuclear Medicine of the American College of Radiology and the Georgia Radiological Society.

Union Camp Corporation has named **Dearing A. Nash,** as medical director of the Savannah plant and the company's unbleached division which includes facilities in Alabama and Michigan. Dr. Nash was appointed chief of staff of Candler Hospital in 1969 and Memorial Hospital in 1973.

E. Garland Herndon and **Robert E. Wells** of Atlanta have been selected as new members of the Board of Directors of Blue Cross of Georgia/Atlanta, Inc.

Merwood M. Jones, a member of the medical staff at South Fulton Hospital, has been elected to Fellowship in the American College of Obstetricians and Gynecologists.

New president-elect of the American Roentgen Ray Society is **Ted F. Leigh,** professor of radiology at Emory University Clinic in Atlanta. Leigh will take office at the next annual meeting of the society in Atlanta in September 1975.

Wood W. Lovell of Atlanta is serving as general chairman on the arrangements committee for the annual scientific meeting of the Southern Medical Association November 17-20. Also serving on the committee are **Edwin C. Evans,** president of MAA, **Thomas W. Marks, Charles Scott, Lamar B. Peacock** and **John M. Roberts.**

Clinton D. McCord, Jr., presented a paper and aided in teaching two courses at the American Academy of Ophthalmology and Otolaryngology meeting in Dallas in October.

Atlanta otolaryngologist **Robert Franklin Thompson** has moved his practice to Newnan, where he was born. Dr. Thompson serves as chief of E.N.T. at Piedmont Hospital, is on the hospital staff at Newnan, Coweta General, Doctors Memorial, Northside and Metropolitan Eye and Ear Hospitals, and is on the peer review committee of the Atlanta Foundation for Medical Care.

Third District

Warner Robins physician **Dan Callahan** was honored in Washington, D.C. in mid September by Georgia Senators Sam Nunn and Herman Talmadge whose praise was entered into the September 16, 1974 *Congressional Record.* Dr. Callahan was awarded honorary life membership in the Reserve Officers Association of the United States at the group's annual convention in Atlanta July 6. Callahan was praised by Talmadge for his efforts in a Vietnam provincial hospital in 1966 and later campaign to persuade drug manufacturers to donate medicines for such facilities. He also has been active with the Georgia Association for Retarded Children and Warner Robins Community Chest.

Fourth District

H. F. Anthony of Thomaston addressed the Woman's Auxiliary of the Upson County Hospital on the topic of the history and use of x-ray at a September 24 meeting.

Byron Dunn has joined **Ronaldo Nodal** in the practice of gynecology and obstetrics in Conyers and Rockdale County.

New physicians in Hogansville are **Yavuz Tarcan** and **Orhan Yorukoglu.**

Fifth District

Napier Burson, Jr., has been appointed Chairman of the MAA's committee to obtain nominees for the annual Aven Cup Award, which Burson received in 1972.

Newly-elected president of the Georgia Society of Internal Medicine is **Louis Felder** of Atlanta. He succeeds **Joseph M. Turner.**

Colon H. Wilson, Jr., has been promoted at Emory to professor of medicine (rheumatology) and associate professor of physical medicine. Dr. Wilson currently serves as president-elect of the Southeastern Section of the American Rheumatism Association and is a member of the National Executive Committee of the Arthritis Foundation.

Sixth District

Gordon W. Jackson of Macon has returned from six weeks in Vietnam serving as consulting professor of obstetrics and gynecology to the University of Saigon. Dr. Jackson is assistant clinical professor of obstetrics and gynecology for the Medical College of Georgia.

The Monroe County Jaycettes learned of techniques in detecting breast cancer from **Patton Smith** of Forsyth.

Seventh District

Grover J. Brown has begun the general practice of medicine in Lindale moving from Cartersville where he

served nine years. Dr. Brown is a graduate of the Medical College of Georgia and served his internship at Floyd Hospital in Rome.

Luke G. Garrett of Austell has joined the board of trustees of Atlanta West Hospital and been named president of the medical staff. **Charles J. Rey** of Austell has been appointed director of emergency services.

Marietta obstetrician and gynecologist **Henry D. Meaders** has been named chairman of the Cobb County Kennestone Hospital Authority. Dr. Meaders is a past president of the Cobb County Medical Society, Kennestone Hospital staff, Marietta Rotary Club and a trustee of Kennesaw Junior College.

Ninth District

Robert Dunn of Cumming is the new president of the Ninth District for 1974-1975, elected at the October 2 fall meeting of the district at Unicoi Conference Center.

DEATHS

Benjamin Russell Burke

Atlanta otolaryngologist Benjamin Russell Burke, 71, died September 18.

The Macon native attended the University of Georgia and Emory University School of Medicine. Graduate work was done at the University of Pennsylvania College of Medicine and Lempert Endaural Institute in New York. During World War II, he was a major with the 43rd General Hospital of Emory University.

Dr. Burke was noted as one of the first specialists in the South to perform the fenestration operation. He served as chief of eye, ear, nose and throat at Georgia Baptist Hospital and Henrietta Egleston Hospital for Children, and was on the staffs of Emory, Crawford W. Long, Piedmont and Grady Memorial hospitals.

Professional membership was held in the American Board of Otolaryngology, American Academy of Ophthalmology and Otolaryngology and the American Laryngological, Rhinological and Otological Society. He was a member of Alpha Tau Omega and Alpha Kappa Kappa medical fraternity, the Capital City Club, Piedmont Driving Club, American Legion Post No. 134 and the Military Order of World Wars.

Survivors include his widow, the former Mary Preacher; daughter, Mrs. Foy L. Hood of Atlanta; and son, B. Russell Burke, Jr. of Jackson, Mississippi.

David Edman Quinn

Former VA Hospital director, David Edman Quinn of Dublin died September 29 at the age of 73.

Dr. Quinn was born in Dennison, Ohio and had lived in Dublin since 1948 when he became director of the VA Hospital, a post he held 11 years. He was medical director of District 26 of the Georgia Department of Public Health for 11 years, and served in World War II.

He held membership in the First United Methodist Church, was a Mason, member of the Dublin Rotary Club, Elks Lodge and Country Club.

Dr. Quinn is survived by his widow, Mrs. Arliene Smyth Quinn and brother, Julius Quinn of Painted Post, N.Y.

Bruce Threatte

A former president of the Muscogee County Medical Society, Bruce Threatte, died September 16 at the age of 76 in St. Francis Hospital.

The South Carolina native was born in 1898. He attended an Atlanta business college, then enlisted in the U.S. Army. He later attended Auburn University where he was president of the Pre-Medical Society, and was graduated from Emory University School of Medicine in 1924. His internship was served at Grady Hospital in Atlanta, Charity Hospital in Shreveport, La. and City Hospital in Columbus.

Dr. Threatte's practice in surgery, gynecology and obstetrics was begun in Columbus in March 1928, and at one time he was chief of surgical service at what is now The Medical Center. He was a fellow of the American College of Surgeons and the Southeastern Surgical Congress.

Survivors include his widow, Mrs. Annette B. Threatte; three brothers, Bernard Threatte of Atlanta, James Threatte of Lakeland, Ga. and Quentin Threatte of Babson Park, Fla.; two sisters, Mrs. J. J. Hollomon, Jr. of Panama City, Fla. and Mrs. Coy E. Jones of Conyers.

HEPARIN UTILIZATION COMMITTEE FORMED TO DEAL WITH SHORTAGE

There is a national shortage of heparin. Though a crisis situation does not exist in the metropolitan Atlanta area at this time, the Medical Association of Atlanta has formed a metro wide Heparin Utilization Committee.

The purpose of this committee will be to establish an accurate inventory of heparin in the city-wide area and to measure its current utilization. In addition, the committee will make recommendations for the judicious use of heparin and hopefully with conservation and fair sharing of the available supply, a critical situation will be averted.

In addition, the committee will meet with the various pharmaceutical firms to see what can be done to improve the supply of heparin and prevent such a shortage from occurring in the future.

In the meantime, we urge each physician to be aware of this problem and to be conservative in the use of heparin insofar as possible within the scope of good medicine.

Classified Advertising

RATES AND DATA: Space sells at a rate of $5 for 50 words or less for members and $10 for 50 words or less for non-members, payable in advance, with a charge of 10 cents for every extra word. For replies, your name, address and phone number should be included at the end, or an Ad number at the *Journal* may be substituted at no extra cost. Copy and payment should be received by the 20th of the month preceding publication. Mail to the *Journal of the Medical Association of Georgia*, 938 Peachtree St., N.E., Atlanta, Ga. 30309.

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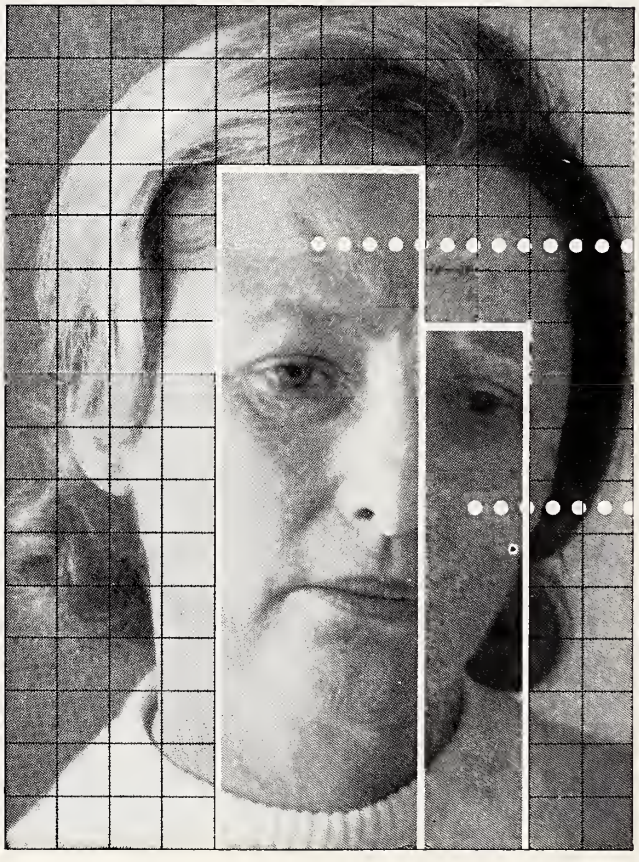
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Atlanta artist Bob Hamill has given contemporary expression to an age-old wish for the Christmas season.

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Simple Guidelines for Detecting Disease in the Infant in the Perinatal Period

ALEX F. ROBERTSON, M.D. *and* EZZAT M. AZIZ, M.D., *Augusta**

DISEASE IN THE INFANT before or after birth requires early detection for successful treatment. The following guidelines are for the use of the primary physician and for situations where referral is advisable due to the complexity of laboratory analyses or need for special equipment.

The maternal factors which lead to newborn illness are well known. In the September 1972 issue of the *Journal of Pediatrics,* Dr. Cornblath and co-

Routine tests for the mother and methods of evaluating the condition of the fetus and neonate are presented.

workers reported on the significance of certain maternal risk factors.[3] These are listed in Table 1, and, as you can see, are related to an age below 16 years or above 30 years: blood incompatibilities, such as the mother being Rh negative or there being an ABO incompatibility; the presence of infection, such as a positive serology test for syphlis or premature rupture of the membranes of over 24 hours; and maternal influences such as diabetes mellitus, pre-eclampsia and drug abuse. Also ominous is the occurrence of fetal distress or those conditions frequently leading to it, such as cesarian section, abnormal presentation, placenta praevia, abruptio placenta, and general anesthesia. Using these maternal risk factors, he reports that with zero risk factors in a maternal history, the infant has a 6 per cent chance of morbidity. Morbidity is defined as "any condition which required a significant diagnostic or therapeutic procedure," for example: indwelling arterial catheterization, parenteral administration of fluid, investigation of possible septicemia or exchange transfusion. With one risk factor, there is a 25 per cent chance of morbidity in the infant; with two risk factors the morbidity is 47 per cent, and with three it goes to 75 per cent. This points out how highly these maternal risk factors may help us in estimating the chance the infant has of being sick. Would it not be reasonable for us to flag charts of the mothers first and then the infants with the appropriate number of red stars indicating the number of risk factors, so that a mere glance at the chart would tell us what the infant's chance of morbidity was? Those with a predicted morbidity of 25 per cent or more could then be placed in a special nursery for closer observation.

Routine Testing for Mother

Ideally, the original approach to the infant is at the mother's first prenatal visit. At that time, the

TABLE 1
MATERNAL RISK FACTORS

Age: < 16 years or > 30 years
Rh negative
ABO incompatibility
Serologic test for syphilis positive
Premature rupture of membranes greater than 24 hours
Diabetes mellitus
Pre-eclampsia
Drug abuse
Fetal distress
Cesarian section
Abnormal presentation
Placenta praevia
Abrupto placenta
General anesthesia
Unregistered

* From the Section of Neonatology of the Department of Pediatrics, Medical College of Georgia in Augusta, Ga. 30902. Dr. Robertson serves as chairman of the Department of Pediatrics.

maternal history is reviewed for illnesses, drug ingestion, and the occurrence of congenital malformations in other family members. When there is a question regarding heritable diseases, it is possible to use the facilities of one of the genetic counseling services† since they can give the most accurate information regarding the fetal risk and the feasibility of prenatal diagnosis by amniocentesis.

The routine maternal laboratory tests should include serologic tests for syphilis and rubella. If the serologic test for syphilis is positive, the physician must determine if and when adequate treatment was given to decide on a course of action. The generally accepted guidelines for this situation are published in "Syphilis, A Synopsis," published in PHS Publication #1660 and available from the Technical Information Services of the Center for Disease Control, Atlanta, Ga. 30333. Consultation is readily available from the Venereal Disease Control Division of the Center for Disease Control in Atlanta.

If the serologic test for rubella is positive indicating previous rubella infection, there is no risk from rubella exposure during the remainder of the pregnancy. If the test is negative and there is later an exposure or probable case of rubella in the mother, the titre can be rechecked either three weeks after the exposure or two weeks after the onset of the illness. If there is a four-fold rise in titre, a rubella infection should be presumed. If this occurs prior to the 20th week of pregnancy, the consideration of abortion may be discussed. If abortion is not performed, the newborn should be checked closely for abnormalities.

Routine testing of the mother should also include blood typing and screening for erythrocyte antibodies. If the mother is Rh negative, her antibody titre should be checked at least twice during the pregnancy to determine if she has developed antibodies which may endanger the fetus. Although Rh antibodies are the most frequent threat to the fetus, other antibodies may be present. Therefore, all mothers should be screened for other antibodies regardless of their Rh type. Panels of cells are available commercially for this type of screening. If antibodies are present, referral to a qualified blood bank center is mandatory for the identification of the specific antibody present, and to an obstetric-pediatric team for deciding whether amniocentesis is needed to follow the effect of the antibodies on the fetus. If amniocentesis is decided upon, in addition to obtaining studies related to the fetal hemolytic process, simultaneous evaluation of fetal maturity should be done. The possible treatment courses open to a fetus with isoimmunization disease are intrauterine transfusion and/or early delivery. These decisions can be made with reasonable accuracy from the bilirubinoid and surfactant measurements. These procedures should obviously be performed in a center prepared to handle a sick neonate.

The occurrence of fetal morbidity and death is quite high in maternal hypertension, diabetes, intrauterine growth retardation and repeated premature deliveries. In pregnancies complicated by these factors, fetal well-being can be followed by frequent maternal urinary estriol determinations in the last trimester. If these levels suggest that the infant is in jeopardy, early delivery may be advisable. In that case, amniocentesis gives us a clue to the degree of maturity of the baby's lungs. By measuring the amount of surfactant in the amniotic fluid, we can estimate fairly well the risk of developing hyaline membrane disease after early delivery. Both the estriol and surfactant determinations are analyses that should be performed in a laboratory where a large volume of this work is being done.

Evaluating the Fetus

During labor the minimal evaluation of the fetus is by frequent determinations of the fetal heart rate. Fetal bradycardia has been related to the time of uterine contraction, and the degree and length of bradycardia and shown to reflect the infant's acid-base status.[4] Two patterns of bradycardia are ominous. The first is fetal bradycardia of any degree beginning late in the uterine contraction. This is referred to as "late deceleration" and implies a decrease in utero placental exchange. The second ominous sign is a severe bradycardia of under 70 beats per minute lasting over 60 seconds which occurs any time during uterine contraction and is referred to as "variable deceleration" and represents umbilical cord compression. It is impossible to give adequate guidelines for reacting to the fetal heart rate. However, any severe bradycardia as described above (under 70 beats per minute lasting over 60 seconds) is an indication for action, either rapid delivery, or more sophisticated fetal monitoring. The latter requires the availability of equipment for continuously monitoring the fetal heart rate, intrauterine fluid pressure, and intermittent determination of fetal scalp blood pH. Since many hospitals do not have the capability of sophisticated fetal monitoring, it is wise to refer high risk cases to a center where this is available prior to or at the onset of labor. The cases in which to consider referral are, again, maternal hypertension (either acute pre-eclampsia or chronic hypertension), diabetes, post-maturity, intrauterine growth retardation, and repeated premature deliveries.

† Currently genetic counseling services are available at the Medical College of Georgia, Emory University School of Medicine, Columbus Medical Center, and the Central Georgia Medical Center at Macon.

The first method of evaluating infants after birth is the Apgar score. The value of the Apgar scoring system is primarily in making someone look at the infant at one minute of age. There is, however, some predictive value also. In *Developmental Medicine and Child Neurology,* 1966, there was a report from the collaborative study for mental retardation of the follow-up of 14,000 infants who were examined for their motor and mental development at one year of life.[1] In those infants whose one minute Apgar score was under seven, approximately 6 per cent had some indication of neurological abnormality at one year of age. Of those infants whose one minute Apgar score was seven or higher, only 1.6 per cent showed abnormality at one year of age. Even more significant, prognostically, was the five minute Apgar score. Those under seven showed 13 per cent abnormality at one year of age, whereas, those seven or higher again showed only 1.7 per cent abnormality at the end of one year of age. Therefore, both the one and the five minute Apgar scores are to a certain degree good prognosticators. When dealing with the five minute Apgar scores, however, you could say that approximately one out of 10 children with a low five minute Apgar score will have some sign of motor or mental retardation at the time he is one year old. This, we think, should be brought to the attention of the parents, not in a blunt fashion, but rather by telling them that their baby was depressed over a long period of time at birth and that, therefore, it is necessary to follow his motor and mental development over the first few years of life very carefully to see if he may need special help in any motor or intellectual area.

Umbilical Cord and Placenta

One should also examine the umbilical cord and placenta. In a follow-up study of infants with single umbilical artery reported in *Pediatrics,* 1973, about 40,000 placentas were examined.[2] Of these, 0.9 per cent showed a single umbilical artery. Among those with single umbilical arteries, 14 per cent of the infants were stillborn or died during the neonatal period or infancy. Those surviving the perinatal period developed as normally as a control group. In the surviving children with malformations (4.1 per cent) more were found to have genitourinary malformation. Therefore, although the single umbilical artery is an indication of an increased incidence of congenital malformations, the abnormal babies tend to die in the neonatal period and no unusual diagnostic procedures need to be performed on the survivors.

Examination of the placenta is also important in that it may indicate amnionitis when you have thickened membranes and a yellow exudate over the fetal surface of the placenta. Also, any twin presentation's placenta should be examined very carefully to determine if there is a monochorionic or dichorionic placentation. When a twin placenta is delivered, the junction of the membranes, usually at approximately the center of the placenta, should be examined. Taking the edges of the conjoined membranes and carefully stripping them apart will lead to the following information: If two thin transparent amniotic membranes separate with no membrane left between, this indicates that you are dealing with a monochorionic placenta. The significance of this finding is that the monochorionic placenta is the one in which there may be arterial or venous communications between the twin's placental circulations leading to the possibility of fetofetal transfusion. In that case, you may have one infant who has respiratory difficulty due to overperfusion and plethora, whereas, the other infant may be in difficulty due to anemia.

Gestational Age

The next method of assessment of the newborn infant is in the determination of the gestational age. We no longer use the previous definition of prematurity as being infants below 2500 grams because we now know that up to 50 per cent of these infants are actually born at term but have had intrauterine influences retarding their growth.[7] Therefore, we should refer to infants below 2500 grams as being low birth weight infants and should then determine their gestational age. The gestational age may be determined by a careful obstetric history, but in certain cases this is either inaccurate or misleading. An assessment of gestational age may be determined by the physical examination of the infant. The physical characteristics that are important in determining gestational age are described in Table 2 which is the table used on all of our newborn charts. Pictures of these physical characteristics are available.[6, 7] Once the gestational age is determined on the basis of the obstetric history and the physical examination, the infant's weight, height, and head circumference should be charted on an intrauterine growth chart. Table 3 is the chart used in this hospital. An infant whose weight falls below the 10th percentile is referred to as Small for Gestational Age (SGA). An infant above the 90th percentile is Large for Gestational Age (LGA). An infant between these limits is called Appropriate for Gestational Age (AGA).

Those infants who are LGA immediately bring to mind the possibility of maternal diabetes. In some cases, intrauterine growth acceleration is associated with congenital malformations of the heart, such as transpositions of the great vessels. Those infants that are below the 10th percentile, SGA, may result from maternal hypertension, placental insufficiency, ma-

MC 423
Rev 12-73

Department of Pediatrics

Estimation of Gestational Age

		Weeks of Gestation											
		29	30	31	32	33	34	35	36	37	38	39	40
Weeks since onset of LNMP													
Genitalia	Testes		High in inquinal canal						Inquinal scratal junctian			Completely descended	
	Scratum		Small rugae inferiorly						More rugae			Rugae complete	
	Labio		Widely separated						L. majara nearly caver L. minora			L. minara covered	
	Clitaris		Prominent						Less prominent			covered	
Ear	Cartiloge		Pinna saft, stays folded				Thin cartilage returns slawly			Thin, springs back		Firm, remains erect	
	Form		Flat, shapeless				Begin incurving af periphery			Partial incurving upper pinna			Complete form
Breast	Tiesue		None				2 mm			4 mm		7 mm >	
	Nipples				Barely visible		Flat areala					Raised areala	
Tone - heel to ear		None	Slight resistance				Difficult		Almast impossible		Impossible		
Sole creases		Nane			1, Anterior transverse		2, Anterior transverse			Anterior 2/3		Creasee over heel	
Hair		Eyebrows + lashes		Fine, woaly							Silky, single strands		

Estimated Gestational Age _____ Weeks

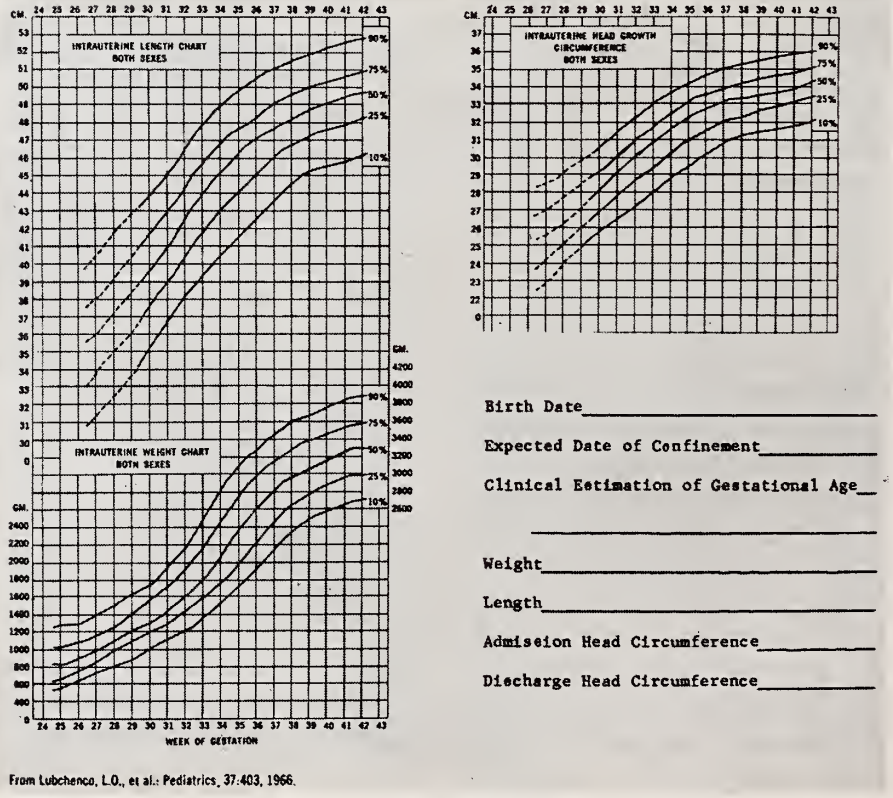
Remarks _____

_____

_____

Date _____ Signature _____

TABLE 2



Birth Date _____

Expected Date of Confinement _____

Clinical Estimation of Gestational Age _____

_____

Weight _____

Length _____

Admiseion Head Circumference _____

Diecharge Head Circumference _____

From Lubchenco, L.O., et al.: Pediatrics, 37:403, 1966.

TABLE 3

Colorado Intrauterine Growth Charts

ternal-fetal infections, twinning, genetic abnormalities of the fetus, or be otherwise unexplained. In this way, the determination of the appropriateness of the intrauterine growth gives us some lead as to what diagnostic procedures should be instituted to determine the cause of intrauterine growth abnormalities. The gestational age and appropriateness of intrauterine growth also gives us an approximation of the likely mortality rate for the infant. Table 4 shows the percent mortality associated with gestational ages and weights of infants.[5] Also, with inappropriate intrauterine growth, we know that we are dealing with infants who may develop specific problems in the newborn period, such as hypoglycemia, which is characteristic of SGA infants. Therefore, these infants should be monitored carefully for their blood glucose levels. Our procedure is to monitor them using capillary blood from the heel and Dextrostix. If the Dextrostix does not show a color change, we draw a venous sample for a quantitative blood glucose determination as we start intravenous treatment with a 10 per cent glucose solution. Screening is performed every six hours for three days. Hypoglycemia is defined as a blood sugar below 30mg per cent in the term (> 37 weeks) infant or below 20mg per cent in the premature (< 37 weeks) infant. Hypoglycemia in the newborn may present as apnea, cyanosis, irritability, convulsions, or be without signs. Therefore, the best procedure is to screen all SGA babies for hypoglycemia.

The physical examination of the infant by the physician[5] should be performed within 12 hours of birth. The earlier the examination the more likely we are to find incipient problems which can be treated. Remember that problems such as respiratory distress and acidosis may be worsened by chilling the infant. Therefore, each examination of a potentially ill newborn should be performed with proper heating of the infant to maintain a skin temperature of 36°-37°C. A radiant heater is the best method of achieving this. The infant should be seen daily with special attention to the presence of jaundice, weight

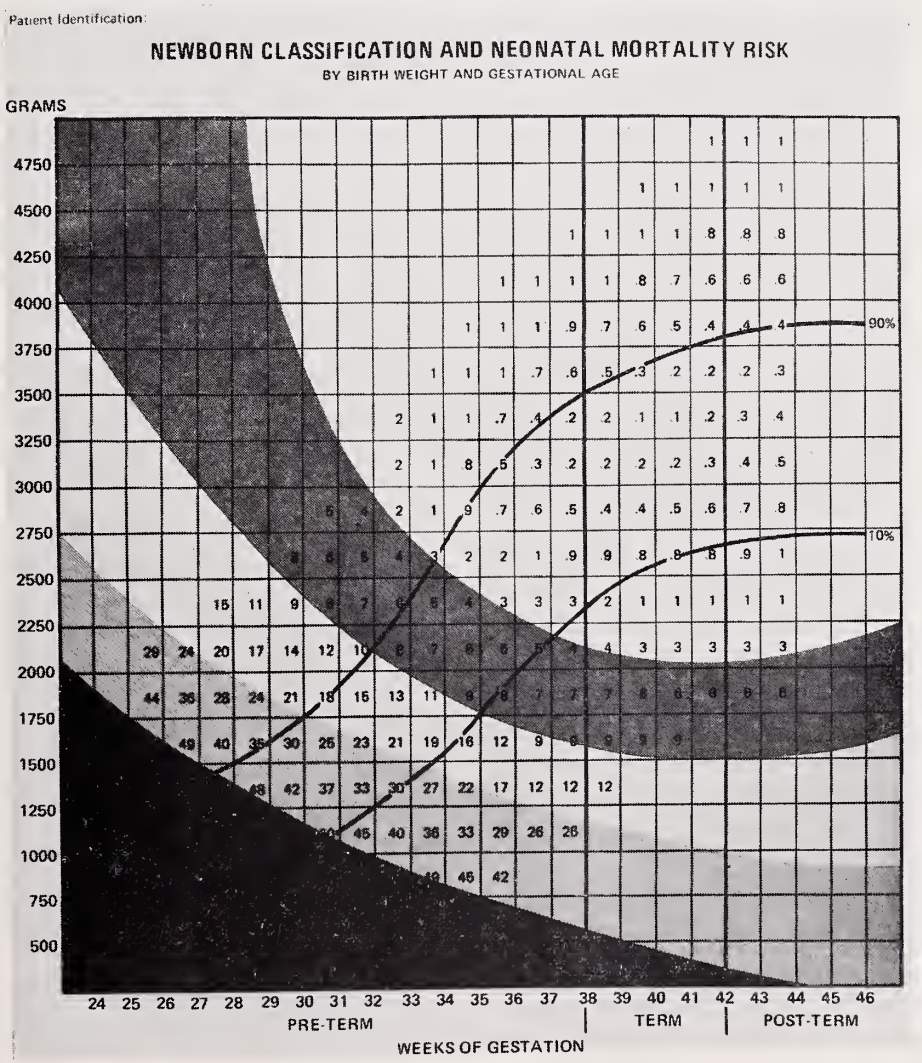


TABLE 4

Interpolated data based on mathematical fit from original data University of Colorado Medical Center newborns, July 1, 1958 through July 1, 1969. Reprinted by permission from Lubchenco, L. O., Searls, D. T. and Brazie, J. V., Jl. of Pediat., 81:4, pp. 814-822 (Oct.) 1972, C. B. Mosby Co., St. Louis, Mo. Distributed by Mead Johnson Laboratories, Evansville, Ind. 47721.

changes, and nurse's notes regarding feeding activity. A physical exam at discharge is sometimes helpful in demonstrating new heart murmurs or jaundice, but it can be an abbreviated exam.

Minimal laboratory testing in the newborn infant should include umbilical cord blood serology, Coombs test when the mother is Rh negative, or type O, or has demonstrable antibodies; hemoglobin or hematocrit, and PKU testing after at least six milk feedings.

Observing the Infant

The final assessment of the newborn infant and the one that is the hardest to quantitate is that of the observation of the newborn infant in the nursery. Experienced nursing personnel do this almost subconsciously, however, there are a few guidelines in the different systems that we can use to assess the infant. These are summarized in Table 5. In respect to the respiratory system, the newborn infant should have a respiratory rate below 60 breaths per minute and this should be without effort. The presence of a more rapid respiratory rate, grunting, retractions, cyanosis, or other signs of respiratory difficulty are definitely abnormal and require investigation and treatment. In regard to the cardiovascular system, the resting heart rate of a normal infant is below 160 and similarly, any excess of this rate or associated cyanosis, respiratory difficulty, heart murmur, or unusual weight gain should be considered as possible indications of a cardiac disease. Ninety-five per cent of normal infants pass meconium within the first 48 hours of life. We feel that any infant who has not passed meconium in 24 hours or who has vomiting or distention should have immediate attention and intestinal obstruction considered. Similarly, most infants void within the first 24 hours of life and any delay in their first voiding should be regarded as a possible abnormality of the genitourinary tract. Also, in male infants, it is very worthwhile to note whether the micturiton occurs with a good stream since one of the more common causes of urinary tract obstruction in male infants is posterior urethral valves, which cause voiding with a poor stream. The central nervous system is the hardest to evaluate. Most nursing personnel know the proper infant cry, the proper level of activity, and the proper feeding behavior of a newborn infant. Therefore, it is somewhat vague but necessary to say that you should evaluate the infant's cry to see if it is high pitched, evaluate his behavior to make sure that he is neither hyperactive nor inactive and to evaluate his neurological responses, such as his ability to suck and his grasp reflex. In addition to these physical signs, we should be aware that variations in temperature control may indicate central nervous system difficulties.

TABLE 5
NEWBORN DISEASE SIGNS

Respiratory rate > 60 per minute
Grunting, retractions
Cyanosis
Pulse rate > 160 per minute
Heart murmur
Meconium not passed in first 24 hours
Persistent vomiting
Distention
Urine not passed in first 24 hours
Absence of a good stream
High pitched cry
Hyperactivity, underactivity
Decreased feeding, suck reflex
Temperature instability
Jaundice in first 24 hours, or over 10mg per cent

All of these assessment methods should be used in evaluating the infant. In some hospitals in Georgia, even these simple observations are either not performed or not recorded. The sick infant, in the future, will be cared for primarily in Regional Neonatal Intensive-Care Units. However, the success of the Regional Centers will always depend upon the quality of care the infant receives at his local hospital and the early recognition and prediction of illness. Therefore, we urge all physicians to institute and record these observations on all newborn infants. ■

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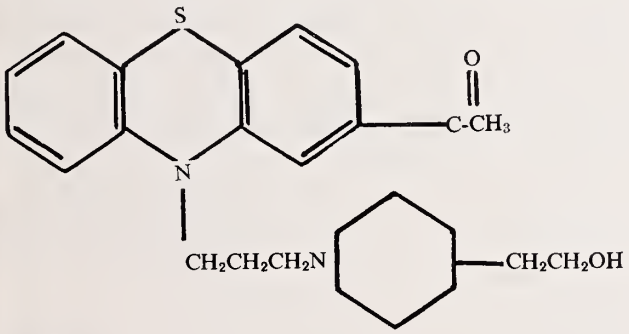
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The author feels that this agent may be quite useful in the hospitalized mentally ill patient.

Piperacetazine Study in State Hospital Patients

LORENZO DEL PORTILLO, M.D., *Milledgeville

PIPERACETAZINE† (Quide®) is a phenothiazine derivative possessing tranquilizing and sedative properties which have been proven to be useful in acute and chronic psychotic patients.[1-4] In order to evaluate piperacetazine for use at Central Georgia Regional Hospital Complex in Milledgeville, Georgia, a 12-week clinical trial was initiated by Dr. Lorenzo del Portillo, chief medical officer of the Hospital.



Procedure

Some 43 mentally ill patients, mostly chronic schizophrenics, were selected for the study. The group consisted of 20 males and 23 females, none of the latter being pregnant during the course of the clinical trial with piperacetazine. The average age of both the male and female groups was 41 years. Prior to the initiation of therapy, all patients were given a physical examination and found to be healthy. Urinalyses and complete blood counts were performed before the study and again at the fourth and twelfth week of piperacetazine therapy. Daily blood pressure and pulse and weekly body weight records were kept on each patient.

After these initial preparations, all previous medication was gradually decreased until discontinued. Some of these medications were other phenothiazine derivatives and some were non-phenothiazine drugs. At that same time we started using a 10 mg dose of piperacetazine twice a day for the first five days and then increased the dosage according to the needs of each individual patient. We attempted to reach a good therapeutic dosage regimen for each patient with the absence of or minimal side effects during the planned 12 weeks of therapy. The highest oral dosage of piperacetazine that we used was 100 mg b.i.d. while the smallest maintenance dose was 25 mg b.i.d.

Evaluation of patient improvement was accomplished collectively by the treatment team. Psychiatric ratings of each patient were done using the NIMH Clinical Global Impressions (CGI) scale, section 1. The CGI consists of a seven-point scale which evaluates mental illness from normal or not mentally ill to among the most extremely ill patients as assessed by the psychiatrist in respect to his total clinical experience.

Mental Status Improvement

In general, very good results in improvement of mental status was observed in patients where seemingly other drugs had failed. Table 1 below divides the patient population studied into various disease categories and gives the resultant clinical improvement picture at the end of the 12-week study with each patient being his own control. A patient who over the 12-week period had improved two or more points as rated on the CGI and/or was furloughed from the hospital prior to the completion of the clinical trial due to significant improvement with piperacetazine was said to have demonstrated marked improvement. Those with a one-point CGI rating change were placed in the "moderate improvement" class and those with no CGI change were designated as not improved.

Although the number of patients in some classes of mental illness is small, some improvement was observed in all patients studied in the following categories: chronic undifferentiated schizophrenia, man-

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† Supplied as Quide® in tablet form by The Dow Chemical Company, Indianapolis, Indiana.

TABLE 1

CLINICAL EFFECT OF PIPERACETAZINE THERAPY IN STATE HOSPITAL PATIENTS

Disease Category	No. of Patients	Marked Improvement[1]	Moderate Improvement[2]	No Improvement[3]
Schizophrenics:				
Chronic Undifferentiated	16	10	6	—
Paranoid	7	4	1	2
Catatonic	4	1	2	1
Hebephrenic	2	—	1	1
Other types	3	1	—	2
Manic Depressive Reaction	2	1	1	—
Involutional Paranoia	1	—	1	—
Psychotic Depressive Reaction	1	1	—	—
Organic Brain Syndrome	3	1	2	—
Alcoholism	2	1	1	—
Neuroses	2	1	1	—
Totals	43	21	16	6

[1] A CGI rating change of 2 points or more and/or furloughed from the state hospital due to improvement in mental status.
[2] An improvement of 1 point on the CGI scale.
[3] No CGI change.

ic-depressive and psychotic depressive reactions, involutional paranoia, organic brain syndrome, alcoholism and neuroses. In the largest category of illness studied, for example, 10 out of 16 chronic undifferentiated schizophrenics demonstrated marked improvement while the remaining six were improved to a moderate degree.

Out of the total group of 43 patients, 86 per cent improved on 12 weeks of piperacetazine therapy. Only six patients did not exhibit any improvement on their CGI psychiatric evaluations.

Adverse reactions or side effects were practically nil. There were no cases of sudden death, jaundice, hematological or cardiovascular disorders or agranulocytosis. Only one patient out of the 43 had to be discontinued due to side effects. This schizophrenic patient experienced drowsiness to the extent that piperacetazine medication was stopped. Only four exhibited tremors which were controlled with the use of trihexyphenidyl HCI.

Summary

Piperacetazine therapy was administered over a 12-week period to various types of mentally ill patients in a state hospital environment. Improvement was observed in 86 per cent of the 43-patient population studied. Side effects were minimal. Four patients exhibited tremors which were readily controlled by an antiparkinson agent. Only one patient was discontinued from the project due to drowsiness. It is felt that piperacetazine therapy may be quite useful in the hospitalized mentally ill patient.

Suggestions for the Research Nurse

In establishing a workable clinical trial of a drug in the hospital environment, guidelines for the research nurse in charge of the patients in the study have been organized in outline form. A registered nurse should function as coordinator of the following suggestions. It is important to utilize all available resources to obtain as much information as possible on the specific drug to be investigated. A simplified pamphlet in easy-to-read content and style containing pertinent drug information should be provided for the patient and family prior to requesting of patient consent for inclusion in the project. Information and discussion sessions can then begin with the staff involved.

I. The nurse's discussion with the staff should include:
   A. The evaluation sheet of patient progress and how it is to be used.
   B. The importance of recording observations of each patient and reporting to the physician and/or co-ordinator nurse for evaluation of dosage adjustment.
   C. The initial physiological (lab, vital signs, weight) work-up and how often it is to be repeated during the entire study.
   D. The assignment and explanation of individual responsibilities of the nursing and paramedical staff during the course of the study.

II. The physician's discussion with the staff should include:
   A. The objectives of the clinical investigation.
   B. The specific time to begin and end the drug study.
   C. The number and type of patients to be included in the drug study with an agreement not to add patients after study begins.
   D. Information on the route of administration,

desired effects and possible side effects of the drug.

E. The plan of "current" drug discontinuation and initial administration of "study" drug.

F. The use or exclusion of other therapeutic drugs during the course of the study.

G. The answering of all questions posed by the staff.

Allow sufficient time for the physician to select patients, write orders and do initial evaluation of each patient with the project co-ordinator. A loose-leaf folder file should be maintained on each patient aside from his hospital record file. This file should contain medical data collected at specified intervals of time during the clinical trial. Evaluation sheets should be updated at regular intervals to chart the progress of improvement or deterioration of each patient while on the study medication. The co-ordinator with ward staff should check evaluation sheets weekly. The co-ordinator and the physician should interview and evaluate each patient at least twice a week. A cover sheet on each patient's file folder should be placed on the outside of the folder for ease of identification. A specimen of a cover sheet is shown below.

All staff members who were involved with patients during the study should assist in compiling the data for final evaluation. The physician in charge may then call a staff meeting for discussion and comments about the project prior to his writing the final summary of the drug study.

Acknowledgement

I wish to gratefully acknowledge the technical assistance of Marjorie Wood, R.N., and Mildred Daniel, R.N., during the conduction of the clinical investigation. Ms. Brenda Lavender and Ms. Connie Underwood of the secretarial staff were essential in preparation of the publication of the paper. The aid of the medical staff and the nursing service during the study at Central Georgia Regional Hospital has also been appreciated. ■

INDIVIDUAL PATIENT COVER SHEET

A. NAME .....

B. HOSPITAL NUMBER: .....

C. DIAGNOSIS: .....

.....

D. AGE: .....

E. SEX: .....

F. WEIGHT: (Before) ..... **(After)** .....

G. NOTATION OF DRUG INCREASE, DECREASE OR DISCONTINUATION: .....

.....

H. NOTATION OF APPROPRIATE OR INAPPROPRIATE BEHAVIOR: .....

.....

I. NOTATION OF INVOLVEMENT IN THERAPEUTIC ACTIVITIES: .....

.....

J. INDICATE DATE AND REASON WHEN A PATIENT IS DISCONTINUED FROM STUDY (FURLOUGHED, DISCHARGED, SEVERE SIDE EFFECTS, ETC.): .....

.....

.....

.....

OTHER REMARKS:

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Pelvic Mass With Faint Linear Calcifications

MARJORIE B. McSWEENEY, M.D. *and* DAVID FROLICH, M.D., *Atlanta**

DR. MARJORIE MCSWEENEY: The case for presentation today is that of a 48 year old female who had previously been in good health. She was admitted with a history of abdominal distention of several weeks duration. Dr. Frolich, would you comment on this film of the abdomen? (Figure 1).

Dr. David Frolich: On initial inspection of the abdomen, the first thing that strikes one is the diffuse haziness throughout the entire abdomen, bulging of the flanks and localization of gas-filled loops of intestine in the central portion of the abdomen. The psoas margins remain visible. These findings are compatible with abdominal ascites.

The second finding which is of significance is the lack of gas in the pelvic inlet. This finding is indicative of a pelvic mass. There are a number of very faint calcifications with a linear pattern along some margins of this mass. These calcifications are only visible on close inspection. These calcifications are compatible with psammomatous calcifications. If this is the case, this would indicate that the mass represents a papillary cyst-adenocarcinoma of the ovary. This finding in association with evidence of ascites would certainly indicate the presence of a malignant process. Mucin-producing tumor of the ovary would also produce calcification, however this type calcification would be larger, denser and more irregular in outline.

Because of the linear nature of the faint calcifications the possibility of pregnancy should be considered, however the calcifications do not have a typical configuration or distribution of early ossification of fetal parts.

Dr. McSweeney: The patient had an intravenous urogram as the next study. This is a representative film. Would you comment on this?

Dr. Frolich: The urogram shows no evidence of obstruction or involvement of either upper urinary tract.



FIGURE 1

Radiograph of the abdomen. The arrows indicate a faint linear calcification on the left side of the pelvic inlet which is barely visible on the original radiograph.

I believe the most likely diagnosis in this case is a serous cyst adenocarcinoma of the ovary. The presence of ascites suggests the possibility of peritoneal metastases.

Dr. McSweeney: The patient underwent surgery. At surgery, the patient was found to have bilateral

* From a weekly x-ray conference, Department of Radiology, Emory University School of Medicine, Atlanta, Ga. 30322. The conference material has been edited by Doctors J. L. Clements and H. S. Weens.

cystic lesions of both ovaries with omental metastases and a large amount of ascitic fluid in the abdomen.

Tumor Examination

Dr. Someren, would you comment on the nature of the cystic ovarian tumors?

Dr. A. Someren: Portions of the ovarian tumors and the omentum were submitted for examination. Histologically, both the primary lesions and metastases represent serous papillary cystadenocarcinoma which are cystic in nature. Usually these lesions are more cystic when they are low-grade in malignancy, they usually tend to be more semisolid or solid when they are more malignant in nature. The histologic examination demonstrates the typical pattern of serous cystadenocarcinoma with numerous papillae showing central fibrous cores surrounded by several layers of neoplastic epithelial cells, many ciliated. The slide also shows numerous psammoma bodies which were seen on radiographs. These are most commonly seen in papillary serous cystadenocarcinoma of ovaries, however, they can also occur in several other tumors such as: meningiomas, some breast tumors, some lung tumors (alveolar cell CA) and papillary carcinomas of thyroid.

Dr. McSweeney: A portion of the specimen was radiographed which demonstrates the appearance of the psammomatous calcification (Figure 2). You will note on the radiograph the sharply marginated sand-like character of the calcifications which is not obvious on the patient's radiograph due to the overlying soft tissues of the patient.

Dr. H. S. Weens: Generally, the psammoma bodies in ovarian cyst adenocarcinoma are scattered throughout the tumor, this tumor had cyst-like characteristics so that the psammomatous calcifications are localized in the walls of the cystic structures which accounts for the linear configuration. This finding has some importance, as we should learn that the linear configuration of the calcification should not keep us from making this diagnosis.

Comment and Summary

Calcification may occur in many lesions of the ovary, although psammomatous calcification is quite characteristic of two papillary tumors of the ovary, the benign cystadenoma and the cystadenocarcinoma. Psammoma bodies may be found not only within the primary tumor but also in distant metastatic foci.

Typical psammoma calcification is less dense than that seen in most calcifications within the abdomen such as fibroids, lymph nodes or calculi. Usually the psammoma bodies are quite small and uniformly distributed throughout the mass producing a diffuse, hazy shadow only slightly more dense than the soft tissues. Lingley describes the characteristic appearance as closely approximating a fine mucosal coating of barium several days after a gastrointestinal examination.

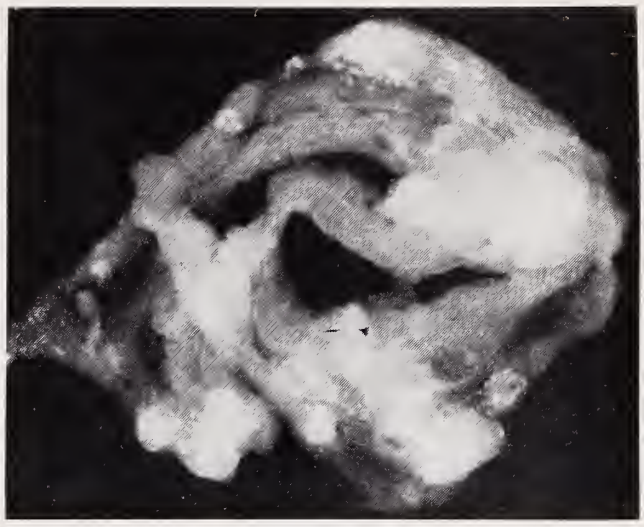


FIGURE 2

Radiograph of a portion of the wall of the cystic serous papillary cystadenocarcinoma demonstrating the sharply marginated sand-like calcification of the psammoma bodies.

The extent of psammoma calcification may be the most marked of any calcification found within the abdomen. One case report describes psammoma bodies within metastases throughout the abdomen, liver and right hemithorax.

The differential diagnosis includes calculi within the pancreas or urinary tract, although contrast studies should help distinguish between psammoma bodies and calculi. Calcified fibroids and lymph nodes are generally more dense and sharply defined than are psammoma bodies. Calcification occurs in simple cysts, but the pattern is that of crescentic calcification. Ingestion of pica or radiopaque drugs may be differentiated by their distribution along the gastrointestinal tract. Mucin producing carcinoma of the G.I. tract should also be considered in the differential diagnosis.

In summary, when typical psammoma calcification is present, the diagnosis of papillary tumor of the ovary may be made. ■

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Several reports on relicensure and recertification, confidentiality, and new problems in legal liability are summarized.

The Socio-Economics of Health Care

JOHN R. McCAIN, M.D., *Atlanta**

THE 8TH NATIONAL CONGRESS on the Socio-Economics of Health Care sponsored by the American Medical Association was held on April 19 and 20, 1974, in San Diego, California. The program had outstanding program participants and the subjects were those which related to the immediate problems in the socio-economics of medical practice. The most significant information provided at the Conference, in my opinion, is summarized in the following report.

Required Continuing Medical Education—How Much and How Soon?

The report of Jerome J. Wildgen, M.D., past president of the American Academy of Family Physicians, provided a fine summary of the subject.

The reasons for required continuing medical education are:

1. A lag by physicians in acquiring the current scientific knowledge.
2. A lag in the implementation by physicians of the knowledge as they acquire it.
3. A public and consumer accountability for the appropriateness of medical services.

Continuing medical education is to be required. So it is advisable for physicians to mould it. The new knowledge should be not only acquired by physicians, but it should also help the patients of physicians. The selection of the subjects for the continuing education of physicians should not be determined by the medical schools but should be determined by those who provide medical care to the patients of our country.

Required continuing medical education will be one of the provisions for maintaining hospital privileges by physicians. The specialty boards and specialty societies support continuing education. State licensing and relicensing and recertification is beginning to include continuing education of the physician as a part of their requirements.

Problems associated with relicensure include the consideration that recertification may fulfill this requirement. If recertification is to be the mechanism by which relicensure is obtained, a problem arises for those physicians who are not currently certified. This problem is also aggravated by the fact that many of these physicians may not be a member of any hospital staff. The mechanism for relicensing of such physicians must be taken into consideration.

The problems related with the recertification examination are numerous. The examination should not be based upon medical activities which are not being undertaken by the physician undergoing the recertification examination.

Recertification in Your Specialty—Is a New Trend Emerging?

The outstanding address on this subject was given by William C. Felch, M.D., president of the American Society of Internal Medicine.

Recertification is proposed and supported in part as a response to public accountability. Recertification proposes to assure the public that the medical care given was appropriate. If the medical profession is to assure the quality of care which it provides, it is first necessary to assess the care. The best methods for assessing accountability are not necessarily the best methods to assure satisfactory quality of medical care.

The original champions of recertification have been the American Academy of Family Physicians and recertification is a requirement in this specialty. Most of the specialty boards are prepared to develop mechanisms for recertification of those who have already been certified through the mechanism of

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each specialty board. The recertification procedures are proposed as voluntary for the majority for the boards at this time.

Most physicians in practice now believe they are providing a satisfactory quality of patient care. Physicians are concerned that the recertifications will be by means of an examination and that the test questions will be posed by academicians and will not be applicable to the actual care of patients. The physician is concerned that such recertification examinations will not relate to the physician's relationship to his patients in the problems of the day to day practice in his office or in the home or in the hospital.

Each specialty board is proposing to include an examination in its recertification process and seek to improve the content of its reexamination. The boards propose to survey the physician's practice and to refine the questions of the examination. Proposals are being made regarding the methodology of testing so that simulation of patient care situations can be included. The greatest concession by the boards at this time is to seek to evaluate performance in practice.

Peer review is proposed by Dr. Felch as a potential mechanism for a new method of recertification of the professional competence of physicians. Peer review has the potential for the ability to conduct the entire evaluation of a physician practice. It can include broad patterns of practice, together with individual patterns. It can assess the quality of care provided by the physicians in the milieu in which they perform their daily services. Peer review can provide an assessment of performance. Medical audits systems by peer review perform an excellent evaluation of the quality of care provided by physicians.

Peer review, up until the present time, has not been coordinated and developed into an organized program which can be utilized as an official mechanism of assuring the quality of medical care provided by physicians. One of the problems relates to the physicians who are not certified by any specialty board. Physicians who have never been certified can not be recertified. The problem of peer review should address itself to the correct evaluation of the care provided by such individuals.

The specialty boards say they are the only ones who are able to recertify a physician. The original certification was made by them and subsequent recertification should be under their supervision and authority. It should be recognized however, that the specialty boards have a vested interest in keeping the total process of certification and recertification under their individual authority.

The criteria for a satisfactory program of recertification should include the following:

1. "The system should apply to all who deliver care; and it should not be threatening to them, nor require excessive preparation on their part.
2. "The system should be closely related to patient care and should be geared as much as possible to the individual physician and his pattern of care.
3. "The system should have a positive thrust, an effort to upgrade care; if it must have a fail point, it should be for a lack of willingness on the part of a physician to *try* to change his behavior.
4. "The system should assess cognitive knowledge, but also other skills. At best, it should assess performance, because ideally this should reflect all skills.
5. "The system should be operated in the private sector; it should be confident enough to welcome public members into its deliberations, and prestigious enough to secure the public's trust. Assessment should beget assurance. When all these conditions are met, we will be truly accountable."

Relicensure—Is It a Potential Reality?

The major address on the subject of relicensure was delivered by Claude E. Welch, M.D., president of the American College of Surgeons.

It is advisable to recognize the difference between certification and recertification as compared with licensure and relicensure. Certification and recertification is an evaluation by non-governmental agencies. Licensure and relicensure are provided by agencies of the government. The licensure may be limited in the duration or in its scope of approved medical care services. Relicensure has become a requirement in three states already. Five additional states have granted authority to their examining boards. The relicensure may involve several methods of evaluating the competence of the physician.

1. A challenging examination.
2. The maintenance of competency in practice.
3. Satisfactory evaluation of his professional services by peer review.

Problems associated with relicensure include the possibility that an excessive reregistration charge may be made to physicians. The relicensure may be of such a nature that the states impose a determination of the number of the physicians in each specialty and also the distribution of these specialists in the state. It is also possible that the federal government may become involved in relicensure.

It is desirable for the AMA to become actively involved in the problems associated with relicensure. Information regarding the complicated facets of relicensure should be available for physicians and also for the state agencies who may be responsible for supervising the relicensure in the individual states. Similar information should be available to the fed-

eral agencies who may become involved in such processes.

Legal Liability—Are New Problems Arising In Malpractice?

The initial presentation was made by Donald J. Fager, J.D., of New York City, New York. One of the major problems in legal liability is involved with *informed consent*. Medical and legal experts should be involved in the information which should be included in determining informed consent. If such expert information is provided by experts it should be possible then for the jury to decide whether or not the individual patients have given their informed consent.

One of the major problems associated with legal liability in New York has been the rapid increase in malpractice claims against physicians. From 1964 until 1973, the number of malpractice claims more than doubled. In 1963 the Underwriting Company for New York paid $1.45 million in losses. In 1973, $17 million was paid in losses. It is possible that physicians may become uninsurable because of the increasing amounts of malpractice lawsuits being incurred by carriers.

Proposals were made for methods of reducing the malpractice losses. No fault professional insurance was proposed as one possible solution. Binding arbitration utilizing screening committees may also be a satisfactory mechanism. The defense between hospitals and physicians in a combined malpractice lawsuit should be coordinated.

Additional information was provided by David S. Rubsamen, M.D., LL.B., of Berkeley, California. Dr. Rubsamen is publisher of the *Professional Liability Newsletter*. Dr. Rubsamen called attention to the experiences in California. These, he suggests, are previews of the experiences which can be expected elsewhere in the country in the near future. In 1969 only three malpractice suits were awarded damages of $300,000 or more. In 1970 there were five cases and in 1971, nine; in 1972, 14; and in 1973, 24. Ten malpractice suits have been awarded damages in excess of one million dollars, five of these being within the last 14 months.

One of the very significant changes which is taking place within medical liability lawsuits, according to Dr. Rubsamen, is that of the corporate responsibility of the hospital. Decisions are currently under appeal. The hospital, in these decisions, has been declared to have a corporate responsibility through peer review to see that the patients within their institutions are not hurt by any ordinary care standards. The proposals of such decisions provide higher standards of medical care than are currently being required by the Joint Commission on Accreditation of Hospitals. Under such decisions it would be possible for a Jury to say before any accident has occurred that the hospital has the responsibility to determine that the physicians practicing within its walls are providing competent medical care. The decisions involving the corporate responsibility of hospitals are currently under appeal to the California State Supreme Court. If the decision is upheld the corporate responsibility of hospitals will go into effect immediately in California. Other states may follow suit in rapid succession.

Confidentiality of Medical Care—Can It Be Effectively Preserved?

The speaker on this subject was Arthur R. Miller, LL.B., professor of law at Harvard University. The goals of medical care for satisfactory accountability and, at the same time confidentiality of medical records, are in conflict. Accountability seeks to obtain unassailable documentation of its competence. Confidentiality seeks, on the other hand, to maintain the doctor-patient relationship with the information exchanged being maintained on a privileged basis. The confidentiality of medical records includes the information within patients' folders and within filing cabinets. The problem, however, far exceeds this type of physician-patient data. The major problem developing at this time is that of managing automated records. The data by-products of encounters between physicians and patients can be massive. If the data is in on-line automated computers it is available to anyone at any time who has the satisfactory key to the computer. The information within such computer systems may be attractive to individuals on the basis of curiosity or on the basis of a desire to obtain potentially useful information by individuals or organizations whose right to such information may not be reasonable.

It is necessary to develop satisfactory safeguards against unauthorized access to computer stored information. Commercial organizations are able to develop satisfactory keys for safeguarding the access to computer stored data. By such mechanisms it is possible for several hundred competing firms to have data stored in the same computers. The rivalry of such corporations would make the obtainment of cross information by competing corporations highly attractive. It is possible to have satisfactory control keys so that such information is available to properly authorized individuals of their respective companies. Such systems to safeguard the availability of physician-patient encounters is highly desirable and necessary if proper relationships between physicians and patients are to be maintained. ■

PSRO—Some Questions and Answers

The following information is taken from an American Medical Association pamphlet of the same title which is designed to provide general information on the PSRO program. Any requests for the pamphlet or other information on PSRO should be directed to the AMA Division of Medical Practice. The following price schedule applies: 1 to 99 copies, 35 cents each; 100 to 499 copies, 22 cents each; 500 to 999 copies, 21 cents each; and 1,000 or more copies, 20 cents each.

In late 1972, as part of the Social Security Amendments of 1972 (Public Law 92-603), Congress enacted a provision that requires setting up "Professional Standards Review Organizations" (PSROs) to monitor health care services paid for, wholly or partially, under provisions of the Social Security Act. This new section of the Social Security Act has caused much discussion and controversy in the medical profession; the following presents answers to some of the questions most frequently asked about PSROs.

Q. What is a PSRO?

A. As called for in the law, a PSRO would be an organization established to monitor health care services paid for through Medicare, Medicaid, and Maternal and Child Health programs to make sure that services provided are medically necessary, meet professional standards, and are provided in the most economical medically appropriate site of treatment. PSROs are to be federally reimbursed local, multi-county or statewide organizations. Initially, their primary concern will be review of care provided by or in institutions—hospitals and skilled nursing facilities—but individual PSROs may request and be granted authority by the Secretary of Health, Education, and Welfare (HEW) to review other services. Eventually, the law provides that PSROs will monitor all services paid for, wholly or partially, by the three Social Security Act programs.

Q. Does the AMA approve the extension of PSRO to national health insurance?

A. No. At the 1974 Annual Convention, the House of Delegates formally adopted a policy that the Association would work to "detach" any national health insurance program from PSRO. At present, PSRO applies only to Medicare, Medicaid, and Maternal and Child Health programs, and the Association does not believe it should be extended until it has had adequate testing and evaluation in operation. As it stands, PSRO needs amendment and improvement, and should not be applied to all medical care provided in the nation, as it might if PSRO were added to or included in national health insurance plans now under consideration.

Q. How soon will PSROs begin operation?

A. There are few specific deadlines in the law. The Secretary of HEW was given until January 1, 1974, to divide the country into the various geographic areas which PSROs would serve, and was instructed to contract with the individual PSROs "at the earliest practicable date after" such area designation. The proposed "area designations" were announced December 20, 1973, and the final version designating 203 PSRO areas was published in the *Federal Register* on March 18, 1974. The first conditional operating contract with a PSRO was signed June 18, 1974; by the end of fiscal year 1974 (June 30) 123 contracts were awarded in 38 states, Puerto Rico, and the District of Columbia. Included were 11 contracts for conditional PSROs, 91 PSRO planning contracts, 13 contracts with state-level foundations and medical societies to function as statewide support centers, and contracts with eight national associations for training programs and technical work.

Q. Who can establish a PSRO?

A. The law requires that, until January 1, 1976, a PSRO must be an association of physicians (doctors of medicine and osteopathy). After January 1, 1976, if the physicians in a PSRO area have not established a PSRO, the Secretary of HEW can appoint as a PSRO a public or non-profit private agency or organization which he believes can do the job.

Q. What recourse do physicians have if they oppose the PSRO proposed for their "designated area"?

A. Until 1976, the Secretary of HEW must notify the physicians in the area of his intent to sign a conditional contract with the PSRO for that area. If more than 10 per cent of the physicians in the area object to a proposed PSRO on the grounds that it does not represent the physicians in that area, HEW is required to poll the local physicians. If more than half of the physicians voting cast their votes against the proposed conditional PSRO, it could not be designated and the Secretary would have to select another PSRO, which would be subject to the same requirements for acceptance.

Q. How will a PSRO work?

A. In March 1974, HEW issued seven chapters of a "PSRO Program Manual" detailing some of the early phases of establishing a PSRO. The Manual (Chapter VII) defines the PSRO hospital review system as an integrated one, based on three major review mechanisms: "(a) concurrent admission certification and continued care review, (b) medical care evaluation studies and (c) analysis of hospital, practitioner, and patient profiles." Final determinations as to the professional conduct of physicians must, by law, be made only by licensed physicians.

Q. What methods of evaluation will be used in PSRO review?

A. As principal points of evaluation and review, the

law states that each PSRO will apply professionally developed norms of care, diagnosis, and treatment, based on typical patterns of practice in its region, including typical lengths of stay for institutional care by age and diagnosis. The PSRO Program Manual indicates that each PSRO will develop or select its own norms.

Q. Can these norms exempt a physician from malpractice claims?

A. Not wholly. The law promises malpractice protection for physicians who provide care falling within the range of acceptable norms, providing they exercise due care, and, in addition, promises immunity for reviewers and others who provide information to the PSRO necessary to its function. However, the requirement for "due care" leaves the question of the extent of legal protection unsettled.

Q. What effect will PSROs have on physicians' fees?

A. The law does not authorize or require PSROs to set fees or review physicians' charges. The PSRO responsibility is to determine whether care provided was (1) medically necessary, (2) of professional quality, and (3) provided in the most economical medically appropriate site (including the determination as to whether care could have been provided on an outpatient basis.)

Q. Can PSRO determinations affect physicians' incomes?

A. Definitely. While the PSRO is not required to determine fees which should be charged, services which do not meet PSRO requirements will not be reimbursed under Social Security Act programs. On the other hand, the PSRO Program Manual indicates that if a fully functioning PSRO is "carrying out its review responsibilities there will be no retroactive review potentially leading to the denial of payment."

Q. I understand that physicians may be fined up to $5,000 if the PSRO deems care provided improper or unnecessary. Is this true?

A. Yes, but not for individual minor departures from PSRO decisions. The law establishes, for care provided under the federally-funded programs, an obligation on the part of physicians to provide only medically necessary services, of acceptable professional quality, at the most economical site appropriate to the patient's needs. If a physician is determined to have violated these obligations to a substantial degree in a substantial number of cases, or to have grossly and flagrantly violated them in one or more instances, he can be excluded from participation in Medicare and Medicaid. In lieu of this exclusion, he can be fined the cost of such unapproved care, up to a maximum of $5,000.

Q. Is there any way to appeal a PSRO decision?

A. If the PSRO decision affects payment of a claim, the practitioner or institution can request reconsideration by the PSRO itself. If the PSRO decision stands, and the amount in controversy is $100 or more, the decision can be appealed to the professional members of the Statewide Professional Review Council, composed of representatives of the PSROs in the state, of the state medical and hospital associations, and of the public. (Statewide councils are required in states with three or more PSROs.) Beneficiaries and recipients under the federal programs have the above appeal rights and, in addition, can appeal to the Secretary if the statewide council confirms the PSRO decision or if there is no statewide council. In cases involving $1,000 or more, beneficiaries and recipients can also seek judicial review of the Secretary's decision. The Secretary must seek appropriate professional consultation before rendering his decision.

Q. Must physicians join a PSRO, and what are the membership qualifications?

A. Membership in a PSRO is voluntary and is open to any licensed doctor of medicine or osteopathy performing professional activities within the area served by the PSRO. According to the "PSRO Program Manual," a license recognized by the licensing authority in the state meets licensure requirements. Interns and residents are eligible for membership if they hold such a current and unrestricted license, and physicians employed by the federal government are eligible if they are associated with institutions subject to PSRO review or if some of their professional activity is outside federal employment. The PSRO cannot require payment of dues to an organized medical society as a condition of membership, but can seek voluntary contributions from its own members.

Q. Are there benefits to becoming a member of a PSRO?

A. In general, the benefits which may result from membership consist in maintaining professional input to the extent possible in the development and operation of the PSRO and the review it performs in the area, rather than leaving management of the program, after 1975, to some possibly non-professional organization or agency. As in any peer review program, the individual participating physician tends to learn as much from the review process as those reviewed.

Q. Will non-participation in PSRO exempt a physician from review?

A. All services reimbursable under the Social Security Act are subject to PSRO review—first institutional services and potentially all services—without regard to whether the physician involved is a member of the PSRO. If a physician treats patients under Medicare or Medicaid, those services will be reviewed, and the PSRO can disallow federal payment for unapproved services.

Q. Can a PSRO member monitor care provided at a hospital where he has staff privileges?

A. PSRO law envisions two types of hospital review. If the hospital's own review committees meet the PSRO's

requirements, the PSRO can delegate the review functions to those committees, in which case hospital medical staff will in fact be performing the review—although final responsibility still resides with the PSRO. However, in hospitals whose own review committees do not meet the PSRO's standards, the PSRO assumes direct reponsibility for review of care in that hospital and the overall responsibility will, in most cases, be assigned to a physician not on the hospital staff—although staff members may still participate in general review activities. No physician may, under PSRO, review services which he has provided or for which he is responsible, nor may he review services provided in an institution in which he or his family has a financial interest.

Q. How much of a physician's time will PSRO take?

A. There are no clear answers to this question. Some PSRO review, as noted above, will be delegated to review committees already in operation; additional review time needed cannot be accurately estimated before PSROs have been in operation long enough to develop experience with the program. However, the law strongly encourages rotating members of review committees so that the job will be distributed among as many physicians as possible. The law authorizes federal payment for administration of the program.

Q. What preparations can physicians make for PSRO review?

A. A primary concern should be to keep informed concerning developments—one source being the information reports available from the American Medical Association. A second concern would be to assure that, if a PSRO is developed for a physician's area, it truly represents the medical community and works toward guidelines and review procedures designed to protect professional judgment.

Q. What will happen if a PSRO is not established by the profession in my area?

A. As previously indicated, the PSRO law itself provides that if no professional association establishes a PSRO acceptable to the profession by 1976, the Secretary of HEW is authorized to appoint as a PSRO "such other public, nonprofit private, or other agency or organization, which the Secretary determines to be of professional competence and otherwise suitable."

In addition, the Social Security Act contains review and utilization control requirements besides those in the PSRO section of the law. The Secretary is authorized to waive any or all such requirements when he determines that review and control activities are adequately performed by a PSRO, but, in the absence of such a waiver, these requirements remain in effect. Among the present requirements are: utilization review under Medicare and Medicaid, claims review by Medicare carriers which can retrospectively deny payment for services after actual Medicare payment of claims, and HEW program review teams which have authority to investigate suspected abuse of a program as a basis for excluding physicians or institutions from such federal programs.

Q. Does the AMA support the basic concept of PSRO?

A. The AMA and the medical profession as a whole supported the concept of peer review long before any legislation in this area was proposed, and continues to support peer review. The AMA, however, consistently opposed PSRO during its passage through Congress as too rigidly structured, too regulatory, and allowing too little flexibility for locally-developed approaches to more effective peer review. However, when the bill became law, the House of Delegates adopted a recommendation of the Board of Trustees and the Council on Medical Service that the Association should provide a dominant role of leadership to assure that the best interests of the public and the profession are preserved. While retaining the recommendation for a leadership role for the AMA, the House of Delegates at the AMA Clinical Convention in November 1973 indicated that in its opinion repeal of PSRO would be in the best interest of the American people.

Because of confusion resulting from this policy statement, the House of Delegates adopted at its 1974 Annual meeting, as a "definitive position which cannot be misunderstood," a recommendation that the Board of Trustees be instructed to direct its efforts to achieve constructive amendments to the PSRO law and assure appropriate regulations and directives, and rejected proposals which would have had the AMA seek repeal of the law.

Q. What PSRO activities is the AMA currently involved in?

A. The Association is continuing its Advisory Committee on PSRO, established following the 1972 Clinical Convention of the House of Delegates with representation from the Association itself, from other medical organizations and national health associations, and from the health insurance industry, to make recommendations concerning the program to the Board of Trustees. The Advisory Committee's eight Task Forces have studied and developed recommendations in their assigned areas: Rules and Regulations; Structure and Organization; Guidelines of Care; Communications and Education; Data Collection, Processing, and Storage; Models and Prototypes; Geographical Areas; and Evaluation of Programs.

The impact of these activities will be effected through liaison with federal staff who are developing PSRO regulations, through official comment on proposed rules and regulations, and through Congressional testimony and proposed amendments to the law (such as those already submitted to Congress by the Association).

The Association has also been awarded a federal contract to coordinate the development of treatment criteria or guidelines for reviewers of hospital care. This builds upon work already done under the auspices of the Task Force on Guidelines of Care, which has worked with almost 30 specialty societies in the development of model screening guidelines, to cover those diagnoses responsible for approximately 75 per cent of each specialty's inpatient hospital admissions. These criteria, when developed, can be used by local PSROs as an aid in developing their own "norms" for review of inpatient care. ■

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editorials

God So Loved the World

THERE IS NO OTHER FACT in all history which mankind needs so much to have brought home to it as this: a man by the name of Jesus Christ once stood in our midst. This is the thought of Harnack, the German historian. It should be in the mind of everyone who calls himself a Christian.

Man easily misreads his environment and misjudges his plight. Evil is so prevalent and sin so commonplace that even Christians forget that Christ has come, and is still with us. The distrust and pessimism that blight our national outlook this year are based on bitter experience and the sad knowledge of human passions and human weakness. By human standards these attitudes are quite natural.

But the message of Christmas is one of hope and optimism. The message of the Gospel is "Good News." It is not a prophecy of condemnation but a call to salvation. It is not harsh, nor discourteous, nor pessimistic. It is generous, strong and joyous . . . full of beauty and poetry, conveying vigor and majesty. Our witnessing to the truth of this voice and to the coming of the Saviour will be given by our unity, our mutual love, and by the bonds that draw us closer together in warm fellowship. Our lives must radiate the new commandment "Love one another as I have loved you."

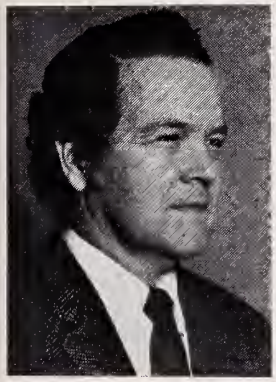
At Christmas God offered Himself to men as He had when He brought them into existence at the dawn of history. At Christmas God proved Himself willing to mingle His life with ours. Despite the fear and vacillation of men, God's purpose is always true and unshaken, and His coming at Christmas is reassurance of our worth which He created and willed to maintain. For the believer, the basic fact of Christmas is that God has come among His People.

Where God is, there is love. Where the People of God are, there must be love. The feast of Christmas is a reminder that: We must love our brothers, near and far. We must love our friends, and even more, our enemies. We must love those who do good to us, and even more, those who need help from us. We must love those who share our beliefs, and especially those who dispute our beliefs.

"God is love and he who abides in love, abides in God, and God in him."

Most Reverend Thomas Donnellan
Archbishop of Atlanta
756 West Peachtree Street, N.W.
Atlanta, Georgia 30308

Reflect, Repent, Renew



How are you thinking about yourself this Season? Are you pleased with who you are? With where you are? With what you're doing?

This is a peculiar time of year. It's a time of comfort and feasting and celebration. It's a time of tradition and reflection and rededication. It's a time of beginning and renewal too. It's a thoughtful time of what's ahead, and where we want to go, and is what we want a good thing?

Each of us as physicians continually must try to satisfy three masters: ourselves, others, and our God. Each of these masters vies for emphasis in our lives. Selfishness and altruism and response to one's superego are difficult to reconcile. Yet reconcile them we must in our day-to-day existence. We must reach a balance almost daily among doing what we must do in maintaining our sanity and self-satisfaction; in carrying out the dictates of our chosen profession in serving the medical needs of our patients; and in serving our God, however that is perceived.

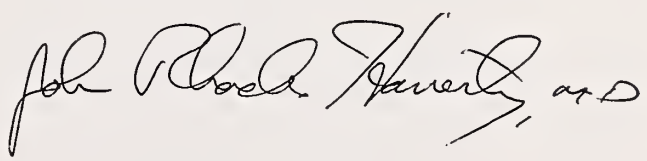
I'm reminded of the joke about the farmer and the agricultural agent where the punch line is something to the effect that the farmer already knew how to farm better than he was doing. This obviously is applicable to medicine also. We're all that way. We all know how to be better physicians (or people, for that matter) than we are. It's the doing that's hard.

So this is the time of year to reflect, to repent, and to renew. Repent may be a hard word for some of us to swallow. Yet I call your attention to one definition: "To change one's mind with regard to past or intended action, conduct, etc., on account of regret or dissatisfaction."

In this sense, then, let us reflect on what kinds of physicians we are, where we are, and what we're doing. Let us recognize the degree of our own dissatisfaction about our activities and goals. And then let us renew our dedication toward becoming more giving, caring people.

Let us serve our three masters. Let us give our best efforts toward serving our patients and others who depend on us. Let us have this as the primary way of satisfying our own inner drives. Then let us rest assured that this will serve our God as well.

Bless you all, and Happy Holidays to you and those whom you love.



John Rhodes Haverty, M.D.
President, Medical Association of Georgia

Breast Cancer—Adjuvant Study in Community Hospital

S. ANGIER WILLS, M.D., F.A.C.S., *Decatur**

THE SURGICAL STAFF at DeKalb General Hospital has entered into a cooperative study with the Eastern and Central Cooperative Oncology Group in a protocol for the Study of Patients with Breast Carcinoma, using prolonged therapy with L-phenylalanine Mustard as an adjuvant to surgery. This is part of a large parent study by the National Surgical Adjuvant Breast Project.

The NSAB Project study is chaired by Dr. Bernard Fisher at the University of Pittsburgh.

The need for such a study is underlined by some of the aspects well known about breast cancer. The survival rate in patients with breast carcinoma is related to the number of metastatic axillary nodes present at the time the patient is first treated. When no metastatic nodes are found, there is a 75 per cent survival rate; patients with positive nodes have a survival rate of approximately 45 per cent. Approximately 65 per cent of patients with breast carcinoma who are resected for cure will have recurrence of their disease within 10 years.

Thus, breast carcinoma most often is not a localized disease, certainly not at the time when it is now diagnosed. If improvement in survival rate is to be obtained, then therapeutic efforts must be directed to those sites of cancerous metastasis beyond the chest wall proper. This study concerns those patients with Stage II disease, that is: those patients with movable tumors in the breast and with one or more positive movable axillary nodes as proven by tissue examination of the surgical specimen. The patient must consent to be included in the study after full information has been given about the aims of the study and procedures to be carried out. The patient must be accessible geographically. Patients with previous oophorectomy are eligible for study if the oophorectomy was not performed for tumor.

Patients are ineligible: (1) If they have been treated previously for their current malignancy including those whose previous treatment was biopsy only, if this was performed more than four weeks prior to radical mastectomy; (2) Patients with malignant tumors other than carcinoma; (3) Inflammatory ulcerating lesions greater than 2 cm. in diameter; (4) Fixation of lymph nodes over 2 cm. in diameter; (5) Prior radiation, surgery, chemotherapy or hormonal therapy for breast cancer; (6) Patients with bilateral malignancy; (7) Patients who are pregnant or lactating. (8) Patients over 75 years of age; (9) Patients with a previous or concomitant malignancy regardless of site except patients with basal or squamous cell skin cancer; (10) Patients who are poor surgical risks, who are at high risk for prolonged follow-up; (11) Patients with significant nodes in the oppositive axilla or supraclavicular area unless these nodes are proven not to be cancer by biopsy; (12) Patients with findings which will relegate them to the category of

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inoperability, such as peau d'orange involving greater than one-third of the breast; (13) The presence of satellite or parasternal nodules.

The patients are divided into two treatment groups regardless of their menopausal status. These groups are age 49 or younger and ages 50 to 75 years.

The patients will be randomized by envelope to placebo or L-phenylalanine Mustard. The clinical investigator will not be aware of which group the patient is in. If in the judgment of the investigator it is necessary to know the therapy for a particular patient, he can obtain the key by calling the appropriate office or by contacting his institution's pharmacy.

All patients are to be treated by the conventional radical mastectomy or by modified radical mastectomy.

The study is to be terminated at the first evidence of treatment failure confirmed by biopsy when possible or after two years of receiving the drug or placebo.

No additional modalities of therapy will be used without at least presumptive evidence and when possible, proven evidence of treatment failure. Once the patient is removed from the protocol because of treatment failure, then further therapy is left to the discretion of the investigator.

The patient is to be followed every three weeks by determination of CBC and platelet count and by clinical examination every six weeks. At three months and six months serum enzyme and metabolite studies are to be done with bone surveys at the end of each six-month period.

While it is true that there is no specific chemotherapeutic agent for breast cancer, it is possible that some of the present agents can effect the growth rate of the tumors if they are given at a time when only a small amount of tumor is present. Phenylalanine Mustard was chosen because it is a drug that is not cell cycle dependent and is most likely to affect cell replication at the time given. It is a drug of low toxicity and is tolerated by the majority of patients.

It is recognized that the control of breast cancer or any other cancer by chemical means depends upon the knowledge of the specific defect in the enzyme-metabolic system of the cancer cell. Until this time comes it seems justified to use those drugs which have shown some effect on tumor growth and have not been grossly detrimental to the host defense mechanism. The responsibility for trying to maintain the balance between these two desired effects of chemotherapeutic agents weighs heavily on the clinician's shoulders in this present time of empiric use of these agents. Carefully planned and monitored prospective studies offer the best chance for evaluating their use in helping the patient with non-resectable cancer at the present time.

Addendum

Because of the favorable increase in disease-free period in the pre-menopausal female, all pre-menopausal females will now receive L-pam and only post-menopausal females will be randomized to placebo. ■

GEORGIANS EARN FELLOWSHIP IN AAFP

Thirty-two Georgia physicians were inducted into Fellowship in the American Academy of Family Physicians during ceremonies October 15 in Los Angeles, Calif.

This Convocation and Inaugural Ceremony came in the middle of a four-day scientific assembly which attracted some 4,000 family physicians, who are required to earn 150 hours of continuing education every three years to retain membership.

Those Georgians inducted were: Avery P. Beall, Adel; John H. Bihl; William R. Bottoms, Cumming; Perry Greene Busbee, Cordele; Claud Pope Cobb, Jr., Rome; William C. Ford, Lavonia; Gurdon R. Foster, Jr., McDonough; Lawrence Lee Freeman, Chamblee; John Robert Harrison, Chamblee; Irving Dale Hellenga, Toccoa; Julio J. Hernandez, Baxley; Emory W. Holloway, Jr., Commerce; Peter Hydrick, East Point; Charles G. Johnson, Forest Park; Milton I. Johnson, Jr., Macon; George R. Jones, Chamblee.

Daniel Rawls Luke, Gainesville; James Edward Marlow, Dalton; Aldine Marcus Mays, Jr., Stockbridge; William L. McDaniel, Jr., Dalton; Frank A. Moorhead; William H. Nichols, Jr., Canton; W. Lanier Nicholson, Hiawassee; Guerrant Heath Perrow, Jasper; Leander K. Powers, Savannah; Fred Huie Simonton, Chickamauga; David Samuel Sowell, Atlanta; Robert J. Starling, Donalsonville; Donald Ray Thomas, Dalton; Manuel Tovar-De-Hoyos, Valdosta; Samuel Victor, Waycross; Robert Miletus Wynne, Macon.

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Confidentiality of Patient Information: A New Basis of Physician Liability?

JONATHAN B. MACDONALD, *Atlanta**

PHYSICIANS ARE AWARE of the ethical precepts of their profession articulated in the Hippocratic Oath, and in the Principles of Medical Ethics promulgated by the American Medical Association. Physicians generally conduct themselves and their practice of medicine in compliance with these precepts because they are ethical men, and because compliance is a condition to the granting and retention of the license to practice. A recent decision of the Supreme Court of Alabama[1] adds another practical reason for carefully complying with one particular ethical principle—the confidentiality of the information communicated to the physician by the patient either verbally or through examination and treatment.

In the Alabama case, the plaintiff sought damages for the voluntary disclosure by his doctor to his employer of information obtained in the course of treatment. The disclosure was contrary to the patient's express instructions and resulted in the dismissal of the plaintiff patient from his employment. The patient contended that the conduct of the physician made him liable under three independent theories: breach of fiduciary duty, invasion of privacy, and breach of contract.

Reasoning in Alabama Case

In its well-reasoned opinion, the Alabama Supreme Court first noted that all three theories were being considered for the first time for the State. The court next referred to the existing authority in other jurisdictions[2] and discussed the policy considerations involved in imposing liability for such disclosure. The court then noted the power and duty of the State Licensing Board for the Healing Arts to suspend or revoke a physician's license for betraying a professional secret, as well as the pledge in the Hippocratic Oath and the Principles of Medical Ethics[3] not to reveal confidences entrusted in the course of treatment. The court finally noted the judicially recognized parameters on the concept of privacy[4] and the justified expectation of confidentiality by the patient. The court concluded that a physician does owe a fiduciary duty of confidentiality to his patient, that modern concepts of privacy extend to such confidentiality, and that confidentiality is implied in a contract for services between a patient and his physician. Accordingly, the court held that the unauthorized and unjustified disclosure of such confidential information is a basis for liability under all three theories, as the plaintiff contended.

Unlike Alabama, such a suit in Georgia would not be novel. In 1957, the United States District Court for the Southern District of Georgia, Savannah Division, dismissed the complaint against a physician, laboratory and hospital in an action for damages brought by an employee who was dismissed from his employment

* Prepared at the request of The Medical Association of Georgia. Mr. Macdonald is an associate in the firm of Powell, Goldstein, Frazer & Murphy, General Counsel to the Association, Eleventh Floor, Citizens and Southern National Bank Building, 35 Broad Street, Atlanta, Ga. 30303.

based on the unauthorized disclosure of the alcoholic content of a blood sample by the defendants.[5] Addressing the issue of whether there is a relationship under Georgia law between patient and physician which prohibits a disclosure of information transmitted to the physician by the patient, the court broadly concluded that no legally recognized confidential relationship between doctor and patient exists in Georgia.

In light of the recent Alabama decision, it would appear unwise to rely upon the opinion in the solitary Georgia case on point to establish immunity for unauthorized disclosures by physicians in the state. Rather, it is possible that reference to the Alabama and other cases and the arguments included therein would result in establishing similar theories of liability in Georgia. As was noted in the Alabama case, neither the reasoning nor the result of the Georgia case is impressive, as the opinion fails to adequately separate the issues of the existence of a legally recognized privilege of the patient to prevent the testimony of his physician and a duty of confidentiality in extrajudicial communications.

In contrast, the thorough treatment in the Alabama case and the similarity between Alabama and Georgia law indicates that the Alabama theories might be adopted in Georgia. In Georgia, like Alabama, there is no statutory physician-patient testimonial privilege, although there is a psychiatrist-patient testimonial privilege.[6] The existence of such a privilege would provide a clearer basis of liability for disclosure, but the non-existence of such a privilege does not prevent liability, as the Alabama Superme Court clearly states. Analogous to the licensing authority in Alabama, Georgia physicians are licensed by the Composite State Board of Medical Examiners, although where the Alabama authority has the power and duty to suspend or revoke a physician's license specifically for disclosing a professional secret, the Georgia Board's power is more general, relating to unethical practices.[7] Further, Georgia physicians take the same Hippocratic Oath and practice under the same Principles of Medical Ethics as Alabama physicians. Private actions for invasion of privacy are also recognized in Georgia[8] as they are in Alabama (although maybe not in as strong terms). Consequently, all of these factors point to the possible recognition in Georgia that a patient is justified in his expectations that a physician promises to keep information confidential.

Liability Not Absolute

It should be noted, though, that in Alabama and other jurisdictions that impose such liability, the liability is not absolute.[9] It is unlikely that such liability if recognized in Georgia would be absolute. Rather, the areas of valid objection to the imposition of such liability would likely be covered by affirmative defenses or exceptions. Liability would only exist where a patient-physician relationship is proven to be involved by the facts.[10] Liability would be further restricted generally by the usual defenses of testimonial privilege, express authorization, and implied authorization, as well as the potential requirement of proving malice. Such liability also would be subject to any additional exceptions of supervening interests of society or the private interests of the patients.[11]

A law enacted by the General Assembly of Georgia in its 1974 session treats the issue of defenses to such liability.[12] In doing so, this new law appears to support the proposition that information communicated by a patient to his physician should be or is confidential, although the law does not expressly say so. Although the law does not establish that the communications are confidential or privileged, it does provide that the disclosure of legally protected medical information pursuant to laws requiring disclosure or pursuant to limited consent does not destroy or abridge the confidential character. The law further provides that confidential medical matter is only to be utilized as required by law or within the terms of the consent. Finally, the law provides that any person acting in good faith is immune from liabilities for disclosure or use of medical information pursuant to a legal duty or limited consent. It must be kept in mind, however, that at present

in Georgia the only areas of legally protected medical information are the psychiatrist-patient privilege and certain closely-defined areas that do not affect the general practice of medicine.[13] The only other communications that this law could relate to would involve disclosure to PSRO Review Committees, when and if they are ever established. And, of course, this law overlaps the existing protection provided by Georgia laws for pertinent information disclosed in pleadings and in court.[14]

The very recent decision of the Massachusetts Appeals Court which notes the developing trend in Massachusetts permitting recovery for breach of confidentiality by physicians[15] supports the Alabama decision and indicates a growing trend in this direction. ■

REFERENCES

1. *Horne v. Patton,* 291 Ala. 201, 287 So.2d 824 (1974), *rehearing denied,* January 24, 1974.
2. See cases summarized in Annot., 20 ALR3d, Physician's Tort Liability Apart From Defamation, for Unauthorized Disclosure of Confidential Information About Patient, 1109 (1968).
3. American Medical Association, Principles of Medical Ethics § 9 (AMA 1957).
4. *Smith v. Doss,* 251 Ala. 250, 37 So.2d 118 (1948).
5. *Collins v. Harvard,* 156 F. Supp. 322 (D.C.S.D. Ga. 1957).
6. 13A Georgia Code Ann. § 38-418.
7. 24 Georgia Code Ann. § 84-902, 905, 907, 916(16).
8. *Davis v. General Finance & Thrift Corp.,* 80 Ga. App. 708, 57 S.E.2d 225 (1950).
9. See annotation cited in Note 2.
10. *Massey v. State,* 226 Ga. 703, 177 S.E.2d 79 (1970).
11. See annotation cited in Note 2.
12. Ga. L. 1974, p. 595.
13. See, i.e., 25 Ga. Code Ann. § 88-1908,1909,1910 (disclosure for the limited purpose of research).
14. 29 Ga. Code Ann. § 105-704, 709, 711.
15. *Hannaway v. Cole,* Mass. App., 311 N.E.2d 924 (1974).

GASTROENTEROLOGIC SOCIETY SELECTS OFFICERS, RECRUITS MEMBERS

Julius K. Wenger of Atlanta has been elected president of the three year old Georgia Gastroenterologic Society at its annual meeting at St. Simons Island in October. Dr. Wenger is chief of gastroenterology at the Veterans Administration Hospital in Atlanta and professor of medicine at Emory University School of Medicine.

John P. Wilson of Atlanta is the new vice president and Ronald R. Fagin of Savannah will serve as secretary-treasurer. E. Napier Burson of Atlanta, immediate past president, will represent the 65-member group to the MAG. The Society is made up of a cross section of internists, pediatricians, surgeons and radiologists who have an interest in the digestive system. Membership in this group is solicited from all Georgia physicians with a similar interest who would like to improve their knowledge and experience. The members meet annually to hold a scientific program and exchange information of mutual interest. The visiting speaker for the 1974 meeting was Norton J. Greenberger, chairman of the Department of Medicine at the University of Kansas Medical School in Kansas City. Future meetings may be held jointly with other professional groups.

National surveys recently have shown that the cost of digestive diseases to the United States exceeds $12 billion per year, even when the cost of cancer of the digestive system is excluded from this estimate. Because of increased emphasis on diseases of the digestive system, this group was formed in October 1971 with the first meeting held in February 1972 in Macon. James L. Achord of Macon was the first president. In addition to present and past officers, members of the executive committee who are active are Zachary M. Kilpatrick and Paul D. Webster of Augusta, Daniel Caplan, J. L. Clements, E. W. Donnelly, Harold Asher and David Taylor of Atlanta.

I've told this before . . . .

(Ed. note: A pack of hounds in pursuit of an elusive fox can be beautiful music to the hunter as author J. G. McDaniel shows in his latest story for our feature page. Others wishing to contribute should send their stories to the Journal of the Medical Association of Georgia, *938 Peachtree St., N.E., Atlanta, Ga. 30309.)*

Foxhunting and Opera

I HAVE OFTEN CONTENDED that anyone who loves grand opera would also enjoy listening to 10 or 15 hounds chase a fox. I am not talking about the people who attend opera to see and be seen, nor those who love to "dress up" and display their jewels, nor those who wish to discuss with their neighbors the social functions that so often accompany these gala occasions. I am speaking of those who would wait in line for several hours to get a ticket in the top gallery, if that was the only way to get a seat.

Foxhounds are a breed all of their own. They have to have a good nose in order to follow the scent of a fox. They must have endurance and enthusiasm and, just as important, a pleasing voice. The voice of each dog is different and its quality and tone will differ depending on what position he holds when the pack is in full cry. In every pack there are several prima donnas. They are acknowledged leaders, both by the hounds and by the hunters. When they cry out that they have found a good scent, others leave what they are doing and rush to them. These others usually are the flanker dogs and form the chorus. They serve a useful purpose, however, because if the fox veers to the right or left and the lead dogs overrun the trail, one of these lesser lights will often pick it up on the flank and when he or she does there is a wild enthusiasm about their cry. This continues as long as they are leading the pack. I used to own a bitch by the name of Dot and when this happened to her, she let out a long high-pitched squall from pure ecstasy and continued with it until the lead was taken away from her. Then she settled down to a short-chopped voice.

The fox seems to enjoy the race as much as the dogs do. Sometimes when a red fox feels good, he will run for hours until the dogs lose him. If he doesn't feel spry, he always has several holes he can go in. The gray fox can always climb a tree and usually does when he tires of the chase. Occasionally a fox is caught by the hounds; why I do not know unless he becomes so egotistical that he has too much pride to hole-up or take a tree. Hunters, of course, never kill one. All they are interested in is the music and vocalization of the hounds during the chase.

On a calm, crisp, moonlight night in the fall there is nothing more beautiful than to hear a pack of hounds sing their song. There are baritones, bassos, sopranos, contraltos and all the rest. They sing it because they love it and it's been bred into them for hundreds of years.

In olden days hounds were followed on horseback, which added a great deal to the hunt, because the horses loved it too. Then, the hunt began at day break but with the increase in population and the use of wire fences instead of rail fences, this delightful part of the sport faded.

Back in the 30's a doctor by the name of Harold Nickelson, another by name of O. D. Hall, and I owned a pack of hounds. We used to go down to Madison over the weekend occasionally and hunt with a friend of Dr. Nickelson, who also owned a pack of hounds.

Nick told an interesting story about him. Back in the 20's he invited the old widower up to Atlanta one Friday night to go to opera. The old man had never attended such a function, but agreed to come and Nick thought that he would enjoy it. Nick did not remember the name of the opera but it probably was *Rigoletto*. Little Galli-Curci was the soprano and in one of the beautiful arias she was leading

the chorus and hitting one high C after another. The old man sat leaned forward with one hand cupped behind his ear, completely oblivious to his surroundings. Finally he could stand it no longer. He jumped up and shouted, "Good God, Nick, listen to that litle bitch run that fox!"

J. G. McDaniel, M.D.
820 W. Wesley Road, N.W.
Atlanta, Georgia 30327

Ostomy Self-Help Society Makes Adjustment Easier

Atlanta's famed symbol, the victorious phoenix rising from the flames of its own ashes, has a special meaning to the estimated one million ostomates in the United States and Canada. With this emblem and the theme, "Reborn from the ashes of disease," they have instituted a self-help society, the United Ostomy Association, with an active Atlanta branch that wants to familiarize Georgia physicians with its goals and services.

Any surgery can be difficult for the patient to accept. The disease that necessitated it and the changed lifestyle that will follow it can be an ego-rocking experience for many people. His confidence and self-esteem will be mirrored in the reaction he expects and receives from his family, his fellow workers, his neighbors and friends.

The ostomate often has great anxiety about his acceptability as he goes into therapy after surgery. Questions like "will I bulge? . . . smell? . . . make noise? . . . be able to marry and have children?" are common.

The Greater Atlanta Ostomy Association was formed 15 years ago by patients themselves who realized that the experience and understanding of a fellow patient could be a great help in therapy, explains Mrs. Carolyn Danson, president of the Association. She is an ostomate herself and serves as an enterostomal therapist at Georgia Baptist Hospital.

The 200-member Atlanta group was the first of similar societies now in Augusta, Brunswick, Macon, Rome and Savannah, with groups forming in Athens and Columbus.

One of the more important services of the Association is to satisfy some immediate needs of the ostomy patient. In addition to the counseling the patient receives from his physician, surgeon, nurses and enterostomal therapists before and after surgery, a visitor-fellow ostomate would approach the patient to answer any questions he can. Those involved in the visitation project feel patients often may be unable to fully understand the technical vocabulary of their surgeons, for example, or are too uncomfortable with them to ask the questions that really bother them. "They are thrilled to death to find someone who speaks their own language," Mrs. Danson says. As a further aid in bridging the communications gap, the Association tries to match patient and visitor as to age, sex and type of ostomy.

Visitors are trained in "what to say and what not to say," maintaining a realistic, yet optimistic attitude and putting a lot of faith in the patient that he can handle his new life, says Mrs. Danson. Literature is given to the patient that takes a matter-of-fact approach to the practical questions every ostomate wants to ask.

If possible the visitor works with the family of the patient for they are the "proving ground and sounding board for the patient." Acceptance by the family is of prime importance, she says.

Patients are invited to join the Greater Atlanta Ostomy Association and to use it as a link to other ostomates who can share experiences and information. The Association prints a monthly newsletter that keeps members informed on meetings, social events, tips on using their appliances, etc. The national organization publishes an "Ostomy Quarterly" with helpful information.

The Atlanta chapter has had the honor of supplying the national president for the past two years, M. E. Gambrell. In addition, William C. McGarity, M.D. of Emory Clinic recently has been appointed to the medical advisory board of the United Ostomy Association. Serving with McGarity on the local advisory board are Drs. John T. Akin, Jr., G. O. Bern, L. C. Buchanan, Napier Burson, Jr., Henry Finch, Oscar M. Grablowsky, LaMar S. McGinnis, Jr., Charles Scott, Jr., Charles E. Todd, J. W. Veatch, Jr., and Mrs. Edith Sikes, R.N. and E.T. and Mrs. Jane S. Walker, E.T.

Physicians are encouraged to call upon the Atlanta association and to refer patients to them. The telephone number is (404) 394-7289.

NEW MEMBERS

Alisago, Andres S., Jr.
Walker-Catoosa-Dade—Act—Anes
Tri-County Hosp.
Ft. Oglethorpe, Ga. 30742

Bell, Sidney
Floyd-Polk-Chattooga—Act—Or
Harbin Clinic
Rome, Ga. 30161

Boswell, John R.
MAA—Act—Anes
6237 Blackwater Trail, N.W.
Atlanta, Ga. 30328

Brooks, James C., Jr.
Troup—Act—I
Country Plaza Medical Group
Franklin, Ga. 30217

Cates, Robert M.
Floyd-Polk-Chattooga—Act—ObG
10 Hospital Circle
Rome, Ga. 30161

Choi, Sun Ik
Troup—Act—Anes
801 Cherokee Road
LaGrange, Ga. 30240

Clabby, James W.
Cobb—Act—I
1642 Mulkey Road, S.W.
Austell, Ga. 30001

Colquitt, Alfred O., III
Cobb—Act—Or
732 Cherokee St.
Marietta, Ga. 30060

Craver, Joe M.
MAA—Act—TS
25 Prescott St.
Atlanta, Ga. 30308

Davidson, Gene G.
Floyd-Polk-Chattooga—Act—I
Harbin Clinic
Rome, Ga. 30161

Erkan, Nizami
MAA—Act—Pd
2730 B Felton Dr.
East Point, Ga. 30344

Ghani, Ghaleb A.
MAA—Act—Anes
1365 Clifton Road, N.E.
Atlanta, Ga. 30322

Giddens, Richard D.
Whitfield-Murray—Act—Su
Medical Arts Bldg.
Dalton, Ga. 30720

Gilbert, Frederick E.
Coweta—Act—Path
Coweta General Hosp.
Newnan, Ga. 30263

Griffith, Thomas H.
Cobb—Act—U
652 Church St.
Marietta, Ga. 30060

Hanna, Michael B.
Coweta—Act—Oph
85 Jackson St.
Newnan, Ga. 30263

Harden, Clifford B.
Peach Belt—Act—P
212 Hospital Dr.
Warner Robins, Ga. 31093

Hiern, Barrie C.
Floyd-Polk-Chattooga—Act—Anes
122 Saddle Mountain Road
Rome, Ga. 30161

Hill, John B., Jr.,
Crawford W. Long—Act—ObG
740 Prince Ave.
Athens, Ga. 30601

Hughes, Andrew J.
Bibb—Act—FP
3741 Houston Ave.
Macon, Ga. 31201

Kaplan, Joel A.
MAA—Act—Anes
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Atlanta, Ga. 30322

Kim, H. Hahk
MA—Act—Pd
2788 Bayard St.
East Point, Ga. 30344

King, Stephen
MAA—Act—Pd
6500 Vernon Woods Dr., N.E.
Atlanta, Ga. 30328

Lasky, Richard S.
Walker-Catoosa-Dade—Act—U
409 Dodds Ave.
Chattanooga, Tenn. 37404

McRae, Andrew T., Jr.
Coffee—Act—Su
1004 West Ward St.
Douglas, Ga. 31533

Morgan, Toby S.
Floyd-Polk-Chattooga—Act—Oto
15 John Maddox Dr.
Rome, Ga. 30161

Park, Ih Koo
Walker-Catoosa-Dade—Act—Su
Tri-County Hosp.
Ft. Oglethorpe, Ga. 30742

Rauch, Samuel D., Jr.
Hall—Act—I
410 Broad St.
Gainesville, Ga. 30501

Roddenberry, Harvey B.
Bibb—Act—ObG
740 Hemlock St.
Macon, Ga. 31201

Ross, Grace Rochat
Floyd-Polk-Chattooga—Act—FP
508 N. Main St.
Cedartown, Ga. 30125

Rudell, Jeffrey H.
Coweta—Act—FP
849 Peachtree St., N.E.
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Skeel, David A.
Richmond—Act—U
MCG
Augusta, Ga. 30902

Stretcher, George S.
Richmond—Act—D
MCG
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MAA—Act—Oph
960 Johnson Ferry Road, N.E.
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Utley, Henry G.
Crawford W. Long—Act—Oph
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Vanderpool, Gerald E.
Cobb—Act—Al
6500 Vernon Woods Dr.
Atlanta, Ga. 30328

Weaver, Jerry O.	502 N. Main St.
Floyd-Polk-Chattooga—Act—FP	Cedartown, Ga. 30125

SOCIETIES

The November 5 meeting of the Bibb County Medical Society featured a program on "Living and Teaching in Vietnam" by Gordon W. Jackson, who spent six weeks in the Southeast Asia country as a consulting profession of obstetrics and gynecology.

James T. Flynn has been elected president of the **Colquitt County Medical Society,** William M. Newton is president-elect and Rod Hester will serve as secretary-treasurer.

The **DeKalb County Medical Society** heard from William F. Barthel, head of the Toxicology Division, Center for Disease Control, on the subject, "Toxicology Today or Poisonous Potpourri." The Society's Auxiliary sponsored a successful Art Auction at the end of October which netted a profit of $1,500 that will go to the American Medical Association Educational Research Foundation (AMA-ERF).

Former POW Porter Halyburton was the guest speaker November 12 for the monthly meeting of the **Georgia Medical Society** in Savannah.

PERSONALS

Third District

Columbus orthopedic surgeon **Jose Carlos Serrato, Jr.,** has been elected to the Board of Governors of the American Fracture Association. The election was held at the membership and business meeting of the Association in Atlanta at the end of October. Dr. Serrato served as chairman of the Convention.

Fourth District

Duane Blair of Decatur has been elected chief of staff of DeKalb General Hospital succeeding **LaMar McGinnis. Clyde B. Rountree** was elected vice chief of staff and **Ernest C. Fokes** was named secretary. Departmental officers include **Joseph A. Arnold** for family practice; **Ralph Tillman** for obstetrics and gynecology and **Dr. Rountree** for psychiatry.

Fifth District

Emory professor **John T. Galambos** has received a National Institutes of Health grant to study alternate methods, other than surgical biopsy, to determine the progression of liver disease and identify the activity of the cirrhotic process.

E. Garland Herndon, vice president for health affairs and director of the Woodruff Medical Center, has been honored twice recently by his alma mater, Wake Forest University in Winston-Salem, N. C. Dr. Herndon was selected as one of four to receive the Distinguished Service Citation for his accomplishments in medicine. Others were honored in business, law and fine arts. Dr. Herndon also has been named to the College Board of Visitors of Wake Forest.

A book, *Gynecology Surgery—Errors, Safeguards, Salvage* has been published by **John H. Ridley,** chairman of Piedmont Hospital's Department of Obstetrics and Gynecology.

Sixth District

Macon physicians **Braswell E. Collins, S. Fleetwood Maddox** and **John A. Page** announce the association of Luther E. Brown for the practice of ophthalmology. After eight years of service, Dr. Collins has terminated his tenure as MAG Councilor and has been replaced by vice-councilor **Milton I. Johnson** until the Society's annual elections in December.

Tenth District

Daniel S. Feldman of the Department of Neurology at the Medical College of Georgia presented a paper at the Third International Congress on Muscle Disease in Newcastle Upon Tyne, England in September.

Graham Smith, Jr., chairman of the Department of Dermatology and acting chairman of the Department of Pathology was the invited guest clinician at the annual meeting of the Memphis Dermatological Society in Memphis, Tennessee in October.

Carl Jelenko has developed and patented a burn health healing medicine while conducting research under a National Institutes of Health grant. Patent rights have been assigned to the Medical College of Georgia by the Department of Health, Education and Welfare.

One-time Hardman Cub Award winner for the MAG, **Perry P. Volpitto** of Augusta has been chosen winner of the 1974 Distinguished Service Award of the American Society of Anesthesiologists (ASA). Dr. Volpitto is a professor emeritus of anesthesiology at the Medical College of Georgia from which he retired in 1972, and has served as president of the ASA and Richmond County Medical Society.

DEATHS

Claude A. Almand

Retired southeastern medical director for the Veterans Administration, Claude A. Almand, died October 22, 1974.

Dr. Almand attended Columbia Medical School and was graduated from Emory University School of Medicine. He has been associated with the Veterans Administration more than 40 years, and had practiced pediatrics in Atlanta a few years prior to joining the VA staff.

Survivors include his son, Conroy W. Almand of Pensacola, Florida; and brothers, Judge Bond Almand of Atlanta and Dr. J. M. Almand, Sr., of Warner Robins.

John Marshall Dent

Tifton physician, John Marshall Dent, died October 4 at the age of 37 following a heart attack.

Dr. Dent was born in Waynesboro and had lived in Tifton since 1969. He was a member of the First Methodist Church, Springhill Country Club, the Chamber of Commerce, the American Association of Gynecological Laparoscopists, the Georgia State Obstetrical and Gynecological Society and the American College of Obstetricians and Gynecologists.

He is survived by his widow, Mrs. Mary Widener Dent of Tifton; mother, Mrs. Novine Holcombe Dent of Waynesboro; sons, John M. Dent, III and Michael Thomas Dent; daughter, Sandra Elizabeth Dent; and sister, Mrs. Ned Browning of Winchester, Va.



Management Consultants Tom Zirkle and Leif Beck.

Physicians and Business Managers Gain from MAGNET '74

". . . First time I have stayed awake for a meeting after lunch in 10 years," was one comment received after the power-packed MAGNET '74 Conference at the Fairmont Colony Square Hotel November 9-10. This is only one of several such comments gleened from questionaires filled out by attendees at the meeting.

From an attendance standpoint alone, MAGNET '74 was one of the most successful meetings ever held by the Association as final registration figures show over 220 people came. A new slant was added this year with the invitation being extended to MAG members, business managers, accountants and office aides. The group was almost equally divided between members and their advisors.

Two of the country's leading medical management consultants, Leif Beck of Bala Cynwyd, Pennsylvania and Tom Zirkle of Denver, Colorado, led the attendees through the processes of establishing and maintaining the modern medical practice. The Saturday session was devoted entirely to instruction in how to make a practice more efficient through the use of modern management techniques.

A panel discussion on Saturday, moderated by Leon Curry, M.D. of Metter, dealt with the role of the physician's assistant. Other members of the panel were Drs. J. Rhodes Haverty of Atlanta, Dave Roberts of Columbus and Bill Morton of Cairo. Also on the panel was Medex Braner, physician's assistant to Dr. Curry.

The Sunday session was devoted to the physician's personal affairs including topics such as personal financial and estate planning, the physician's relationship to the professional corporation and the new pension reform act.

Via another panel, attendees had the opportunity to expand their knowledge of the HMO law. The panel included Harrison L. Rogers, M.D. of Atlanta who served as moderator, W. D. Jordan, M.D. and Charles Todd, M.D. of Atlanta, Leif Beck and Winston Huff, MAG attorney.

MAGNET '74 program coordinator was Marvyn D. Cohen, M.D. of Columbus. This program has been accepted for nine elective hours by the American Academy of Family Physicians.

The Communications Committee is making plans already for the next MAGNET Conference and will announce topics and location in the near future.



Pro and con of the HMO question were debated by (L-R) Dr. Rogers, Mr. Winston Huff, Drs. Todd and Jordan, Mr. Beck.



The ways in which physician's assistants can be used in a practice were discussed by (L-R) Dr. Curry, P. A. Medex Braner, and Drs. Morton, Haverty and Roberts.

The Month in Washington

Though Senator Russell Long (D-La.) may make an attempt to win Senate approval of his social security-catastrophic national health insurance proposal during Congress's lame duck session, most Capitol Hill observers believe such legislation's chances of passage are less than that of Henry Mencken's snowball in hell.

Reviewing NHI

The American Medical Association is now in the process of reviewing and updating its position on national health insurance, Malcolm C. Todd, M.D., has told Washington groups.

"Our objective is to make the AMA's national health insurance proposal more flexible, while at the same time maintaining certain basic precepts," Dr. Todd said.

"If necessary, we may compromise on the method of financing we adopt. But we are not willing to fund national health insurance through an increase in Social Security taxes; nor are we willing to see the program administered by the Social Security Administration.

"We want a financing mechanism for comprehensive health insurance that will do the most at the least cost. This could involve:

- Increase employer-employee contributions for private health insurance;
- The use of general tax revenues;
- Or, an individual tax credit to be applied toward full health care protection. This latter method was, of course, the method employed in Medicredit.

"The important point is that we cannot countenance greater fiscal and bureaucratic authority for the Social Security Administration or an increase in the Social Security tax.

"Any payroll tax, whether collected under Social Security or not, constitutes the most insidious form of taxation that can be invoked by government. It is a totally regressive tax that weighs heavily on low and middle income workers and lightly on the affluent.

"Finally, the measure that emerges will provide comprehensive health care benefits as well as protection against the catastrophic costs of prolonged illness for every American," Dr. Todd said.

Major Health Bills

A batch of major health bills are hanging fire for the "lame duck" session of Congress. Comprehensive health planning bills have cleared the Senate but not the House. Though no public utility-type regulation is in prospect, other measures strengthening government planning authority abound.

Health manpower legislation with provisions for federal service in shortage areas is through the Senate. House action is expected shortly after Congress returns. There is a possibility that one or both may be stalled in conference as the Administration now wishes simple extension of present programs.

A health revenue sharing bill will be taken up again by a House-Senate conference. This measure extends state health block grants, community mental health centers, family planning, migrant health and neighborhood health center programs. It should secure Congressional enactment this year.

The Health, Education and Welfare appropriations bill still has to be completed.

No chance is seen for passage of the Omnibus Drug amendments bill that would provide Medicare outpatient drug benefits, a Federal Formulary, and the Administration's low-cost drug plans for Medicare-Medicaid patients.

HMO Regulations

The Health, Education and Welfare Department has issued final regulations on benefits and structure of Health Maintenance Organizations, giving the green light to federal grants launching the program.

The regulations set forth the rules and restrictions and benefits that must be followed in order for organizations to qualify as HMOs and receive federal aid. The

DIRECTORY FRAUD STOPPED BY AMA AND POSTAL SERVICE

A fraud directory scheme has now been stopped by the U.S. Postal Service which as of November 1, 1974 was returning to senders all mail addressed to the Mayo Research and Publishing Company for the *International Medical Directory of Physicians.*

The scheme involved computer-punched "invoices" sent to thousands of physicians calling for payment of $185 for the purchase of the directory. Terms in light print on the reverse inform that payment is for listing the physician's name in the directory that will be published no later than December 1975—it is an offer of services, not a demand for payment, as it appears to be.

Apparently the names on the invoices had been taken directly from the AMA's *American Medical Directory* but the AMA emphasizes that it did not provide or approve of its use.

Likewise the use of "Mayo" in the company's title should not be confused with the publications of the Mayo Clinic or a directory of medical specialists. A Hong Kong address was listed as the place to which payment was to be made. The British government reports that the "company" is not registered, as required by law, in Hong Kong.

$325 million HMO program was approved by Congress in 1973.

Grants can now be made among the 125 groups that have applied for funds to conduct feasibility studies, planning and development.

The HMO Act authorizes federal support for five years "to demonstrate more broadly the concept of organizations delivering comprehensive health care services on a prepaid basis." Last year Congress appropriated $61 million. The Administration sought $60 million this year, but the Senate approved only $18 million because of a delay due to the development of the complicated regulations.

The regulations specify basic services to be provided in return for fixed payments made on a periodic basis without regard to the frequency, extent, or kind of services provided, with the payments set on a community rating system. These may be supplemented by what the regulations call "nominal copayments" limited under a variety of formulas.

Before the HMO program can be launched still more regulations will have to be completed. The most important is the statutory requirement that employers with more than 25 workers offer the employees the option of joining a qualified HMO if one is available. These proposed regulations are slated to be issued soon, but final ones are some months off.

Though suggestions were made to exempt HMOs from Professional Standards Review Organization (PSRO) authority, HEW rejected them, declaring that there is a need "to assure that suitable procedures are applied to HMO services to assure they conform to appropriate professional standards for the provision of health care applicable to other providers."

Basic HMO benefits must include:

- physicians services (including consultant and referral services by a physician);
- outpatient services and inpatient hospital services;
- medically necessary outpatient and inpatient emergency health services;
- short-term (not to exceed 20 visits), outpatient evaluative and crisis intervention mental health services;
- medical treatment and referral services (including referral services to appropriate ancillary services) for the abuse of or addiction to alcohol and drugs;
- diagnostic laboratory and diagnostic and therapeutic radiologic services;
- home health services; and
- preventive health services (including voluntary family planning services, services for infertility, preventive dental care for children, and children's eye examinations conducted to determine the need for vision correction).

Prepaid Plans

The General Accounting Office has charged that per capita payments for Medicaid patients enrolled in prepaid health plans in California exceeded average fee-for-service costs on one of two pilot projects studied.

In a report to the Senate Finance Committee, the GAO also said that Medicaid enrollees in the prepaid plans "have made many complaints about the quality of medical care," especially the lack of a personal family physician.

About 3 per cent of the Medicaid patients in fiscal 1972 dropped out of the plans each month with the exception of the Sacramento Foundation Community Health plan where the rate was only .3 per cent, a difference attributed by GAO probably to the fact that the Foundation allows most enrollees to remain with their family physicians.

However, GAO, Congress' watchdog on federal expenditures, said the Foundation was paid $406,000 more for Medicaid patients than per-capita fee-for-service estimates for the group.

The agency recommended that the HEW Department establish surveillance mechanisms to insure that costs of HMO do not exceed the costs of fee-for-service.

Medicare Comparison

A controversial draft report that showed two Blue Cross Medicare intermediaries with substantially lower administrative costs than those of the Social Security Administration's Bureau of Health Insurance has been pulled back by the General Accounting Office and is being redone, according to the *Washington Report on Medicine and Health*. BHI has objected to the comparison as invalid and GAO has protested Blue Cross use of the draft which had been put out on a confidential basis.

Kaiser Plan PAs

Physicians, patients and fellow workers have reacted favorably to the Physician Assistants (PA) employed in a pilot experiment by Kaiser Foundation Health Plan, according to a report on the program.

At present seven PAs are on duty at Kaiser. The first was hired in 1970, a graduate of the Duke University PA program and a former military corpsman.

There was concern by some physicians and administrators, but "the greatest resistance came from the nursing department," writes Kaiser official Paul Lairson, M.D., in *Inquiry*, the Blue Cross Association magazine.

As the nurses began to work with the PA and learned from experience that there was more of an "equal relationship" with him than with the physicians, they became a "traditional team," Dr. Lairson declared. Furthermore, "all but one of the physicians who worked in the clinic with the PA came to favor expanding the program," he said.

The PA saw approximately 20 patients per day at the Vancouver, Washington, clinic. He was given three physical examination appointments and the rest of his time was rapidly filled with the "treatment of relatively minor medical and surgical problems, whether by appointment or on a 'drop-in' basis." More severe or chronic problems were transferred to the internist or other specialist.

Convention Travel

The tax reform bill before the House Ways and Means Committee has a provision to discourage professional conventions by American organizations in foreign countries.

Exempted would be Canada, Mexico, Bermuda and the Caribbean. The taxpayer must show that it was "more reasonable for the meeting to be held outside North America," to secure a business expense deduction. Not affected would be meetings announced before September 11, 1974.

MONTH IN WASHINGTON / Continued

The amendment is aimed at national conventions being held in faraway tourist attractions where attendees deduct their travel and other expenses as business-connected.

Medicare Deductible Rises

The Department of Health, Education and Welfare has announced that commencing with the first of the new year the Medicare hospital deductible will jump to $92. The present deductible is $84.

HEW said that the $92 deductible is equivalent to the average cost of one day of hospitalization. The increased payment was brought about by rising hospital costs, HEW said.

The Medicare law requires an annual review of hospital costs under Medicare and an adjustment of the portion of the bill for which a Medicare beneficiary is responsible, if the costs have risen substantially.

When the hospital deductible amount changes, the law requires comparable changes in the dollar amounts that a Medicare beneficiary pays toward a hospital stay of more than 60 days, or an Extended Care Facility (ECF) stay of more than 20 days.

When a Medicare beneficiary has a hospital stay of more than 60 days, he will pay $23 a day for the 61st through the 90th day, up from the present $21 per day. If he has a posthospital stay of over 20 days in an ECF, he will pay $11.50 per day toward the cost of the 21st day through the 100th day, up from the present $10.50 per day.

If a beneficiary uses his "lifetime reserve" days, the extra 60 hospital days a beneficiary can use when he needs more than 90 days of hospital care in the same benefit period, will cost him $46 for each reserve day used, instead of the present $42 per day.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

October 20, 1974

Universal Health Insurance Claims Form: Approved, subject to Insurance and Economics Committee review, use of a universal health claim form. If necessary, support for the form will be sought in discussions with the Insurance Commissioner or the Legislature.

MAG Insurance Department: Approved the concept of establishing an MAG office of insurance, with a potential scope of activities to include MAG sponsorship of insurance coverage in the malpractice area, life and health, home owners, automobile insurance, workmen's compensation, etc.

Amalgamated Concurrent Hospital Care Review Programs: Received report on the lack of progress in pursuing the development of a concurrent hospital review program to combine elements of both the CHEC and the Blues programs.

Cancer Management Network: Discussed the changing relationship between the network and MAG. Approved a proposal that the MAG be the contractor for the SEER Program with the network as an advisory body.

Laboratory Quality: Report of the Ad Hoc Committee on Laboratory Quality was received with recommendations to establish a voluntary proficiency evaluation program for physician laboratories in private offices. Requested a further report on a specific program that could be implemented by MAG.

Amendment to the Voluntary Sterilization Law: Voted to support the deletion of the consultation requirement and consent of spouse requirement in the State voluntary sterilization law.

Georgia Medical Care Foundation: Received Foundation report including request for MAG financial support in the sum of $6,000 for implementation of the CHEC Program for a six-months period in three hospitals.

Appointments: Education Committee, R. Dale Cooper, Atlanta; Second District Medical Disciplinary Investigating Committee, Maurice B. Tanner, Thomasville.

HIGHLIGHTS OF EXECUTIVE COMMITTEE OF COUNCIL

November 10, 1974

Socio-Economics Congress: Learned of AMA's interest in having MAG co-sponsorship for National Congress on Socio-Economics of Health Care, April 25-26, 1975 in Atlanta.

ASIM Meeting: Advised of American Society of Internal Medicine's plans to conduct its annual meeting in Atlanta in April 1976.

Utilization Review Forum: Received report on utilization review meeting conducted by the Bureau of Health Insurance. Approved joint sponsorship of future meetings by MAG and Georgia Hospital Association.

AMA Dues: Received report on the proposed AMA dues increase of $90, effective January 1, 1975.

Community-Based Cancer Program: Received report on planning contract for this program. Further clarification on MAG eligibility as contractor to be obtained and reported on in January.

HMO Legislation: Reviewed use of proposed HMO legislation. Noted that consideration in the Legislature is not probable until a committee has had an opportunity to study HMOs.

Mercer Medical School: Heard presentation by Dean Nat Smith on plans for the proposed medical school in Macon.

Concurrent Hospital Care Review: Received report on progress of Blue Cross, Foundations, GHA and MAG meetings on developing a single concurrent hospital review system for Georgia.

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